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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14886

CERTIFICATE OF DEATH

14887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓	
b. CITY OR TOWN (If outside corporate limits, write name of town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 186 MAIN ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle C	Last ARRINGTON
4. DATE OF DEATH	Month NOVEMBER	Day 27 ₁₉	Year 67
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1884
9. AGE (In years 103 (birthday) yrs.)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED -WESTERN MARYLAND RAILROAD		11. BIRTHPLACE (County & State, or foreign country) GLADE HILL, VIRGINIA	
13. FATHER'S NAME HARRY W. ARRINGTON		14. MOTHER'S MAIDEN NAME MARGARET "CRAFT",	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-10-4882	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac arrest 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Myocardial Infarction, inf., occl. (c) A.S. & H. Cardiopul. disease		INTERVAL BETWEEN ONSET AND DEATH 19 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, well 1961 Post. Sat. myocardial infarct 1961		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 day, 19 1961, to 27 nov, 1967, that (I) (we) last saw the deceased alive on 27 nov, 1967, and that death occurred at 9:45 P.M. from causes and on the date stated above			
22a. SIGNATURE W. A. Van Ormer		22b. DATE SIGNED 28 nov. 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. CEMETERY OR CREMATORIUM CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 1, 1967	
23c. NAME OF CEMETERY OR CREMATORIUM ZION MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) RFD3 CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		ADDRESS	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE NOV 30 1967			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

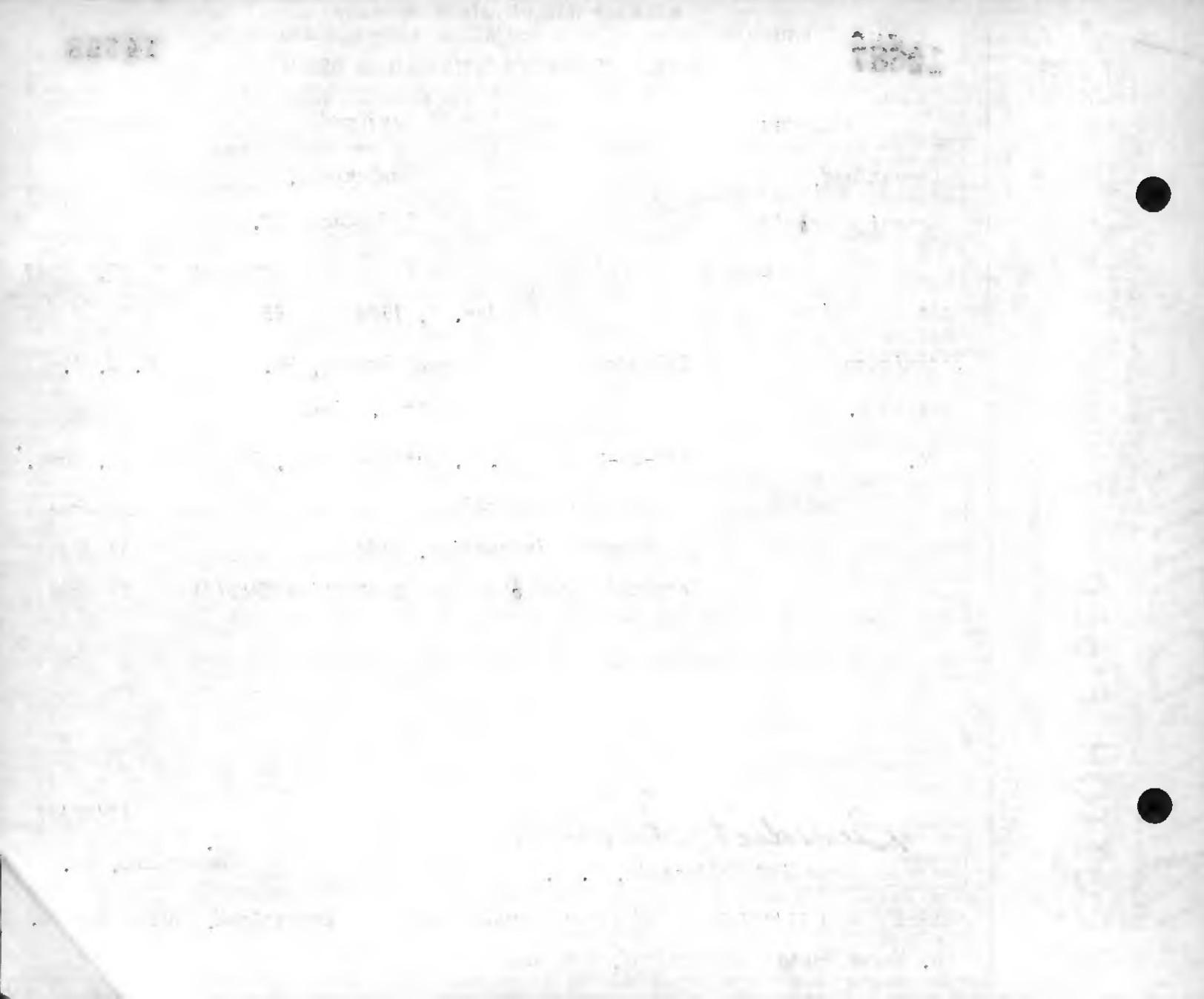
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14687

14698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		f. STREET ADDRESS 547 Greene St.					
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First Lester	Middle Piper	Last Beall	4. DATE OF DEATH November 27, 1967	Month November	Day 27	Year 1967					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 9, 1904	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Laboratory		11. BIRTHPLACE (State or foreign country) Mount Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph E. Beall		14. MOTHER'S MAIDEN NAME Ella M. Piper											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7803		17. INFORMANT Mr. F. Carlton Beall, 547 Greene St. Cumb.		Address Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Broncho pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3 days							
		DUE TO Cerebral infarction, left				16 days							
		DUE TO Cerebral thrombosis due to arteriosclerosis				16 days							
19. MEDICAL CERTIFICATION		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland	(County) Allegany	(State) Md.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Rt. # 9 Cumberland, Md.		22. DATE SIGNED 11/27/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/67		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland, Allegany		(County) Md.		(State)			
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. REC'D. BY REGISTRAR NOV 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #1d 11m #6395 11/29/67 ph CERTIFICATE OF DEATH										14699				
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD									
b. CITY OR TOWN (If outside corporate limits, write RURAL) CUMBERLAND					c. LENGTH OF STAY IN lb 1 MO 7 DAYS									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital					e. STREET ADDRESS RD#1 Londonderry Township					f. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print)		First VELMA	Middle I	Last BINGMAN	4. DATE OF DEATH		Month NOVEMBER	Doy 15	Year 1967	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0		
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 10-11-1903		9. AGE (In years last birthday) 82 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JOHN MADDEN					14. MOTHER'S MAIDEN NAME IDA E. WOLFORD					Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None			16. SOCIAL SECURITY NO.			17. INFORMANT None			18. CAUSE OF DEATH (Enter only one cause per line) for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Ca of Breast			INTERVAL BETWEEN ONSET AND DEATH 6 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Art deb Cva					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. CITY OR TOWN Camp Geller Md (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/16/67 to 11/14/67 , 19, that (I) (we) last saw the deceased alive on 11/14/67 , 19, and that death occurred at 5:45 AM , from causes and on the date stated above.														
22. SIGNATURE R. Williams			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 11/15/67					
22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, (BOTH OR SPECIFY) Burial			23b. DATE THEREOF Nov. 18, 1967			23c. NAME OF CEMETERY OR CREMATORIAL Pa Alto Cemetery			23d. LOCATION (City or Town) Hyndman, Pa. (County) RD#1 (State)					
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.			ADDRESS			25a. REC'D BY REGISTRAR DATE NOV 22 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. *Pages 1 and 2* should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14689

14700

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 63 Grant Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Gilbert	Middle N.	Last Bittner	4. DATE OF DEATH Month November	Day 27,	Year 1967
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-30-83	9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired: Celanese		10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Bittner				14. MOTHER'S MAIDEN NAME Ellen Shaffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>If yes give war or dates of service</i>		16. SOCIAL SECURITY NO. 216-10-6802		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac arrest</i> INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> 4200 Due to <i>Chv. A.S.H.D. with ventricular insufficiency</i> <i>many years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chv. Obstructive pulmonary disease</i> <i>many years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Severe Dehydration</i> <i>Arterio sclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/26 , 1967, to 11/21 , 1967, that (I) (we) last saw the deceased alive on 11/25 1967, and that death occurred at A. M., from causes and on the date stated above at 10:23 A.M.							
22a. SIGNATURE <i>John A. Tupper</i>		22b. DATE SIGNED Nov 21, 1967					
22c. PHYSICIAN'S NAME (Type) John A. Tupper M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 11-30-1967		23b. DATE THEREOF 11-30-1967		23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL		23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEG. MD.	
24. FUNERAL DIRECTOR Joseph R. Durst Jr.		ADDRESS 301 W. PRESTON ST.		25a. REC'D BY REGISTRAR DECP 5		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

14690

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14701

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event with in 72 hours after death.

PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution, Res dence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN b. 1. MONTH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 817 MEMORIAL AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First OWEN	Middle J.	Last BRADY
4 DATE OF DEATH	Month NOV.	Day 13	Year 19 67
5 SEX MALE	6 COLOR DR RACE WHITE	7 MARRIED W DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH APRIL 4, 1895
9 AGE (In years last birthday) 72 yrs	10 UNDER 1 YEAR Months 0	11 UNDER 24 HRS Days 0	12 HOURS Hours 0
100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT	10b KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	11 BIRTHPLACE (State or foreign country) W. VA.	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME OWEN J. BRADY	14. MOTHER'S MAIDEN NAME ANNA M. HINES		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. 214 07 5892-A	17. INFORMANT WILLIAM P. BRADY	Address CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion			INTERVAL BETWEEN SICKNESS AND DEATH 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost (c)			---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 16, 1967	23c. NAME OF CEMETERY OR CREMATORIUM ST. PETER & PAUL CEM.	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT	ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR NOV 16 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

14691

CERTIFICATE OF DEATH

14702

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dans Rock Road		d. STREET ADDRESS Dans Rock Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ruth	Middle E.	Last Brinegar
S SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/22/1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Parkersburg, W.Va.	
11 BIRTHPLACE (County & State or foreign country) Parkersburg, W.Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Brinegar		14. MOTHER'S MAIDEN NAME Clarinda Knight	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Walter Brinegar Address Midland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		"Brother" Cerebral Hemorrhage - Severe arteriosclerotic CVD. INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15 , 1965 to Nov. 9 , 1967 that (I) (we) last saw the deceased alive on Nov 7, 1967 , and that death occurred at 8 A.M. from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 11/10/67-	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg A. Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. RECD BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE NOV 13 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

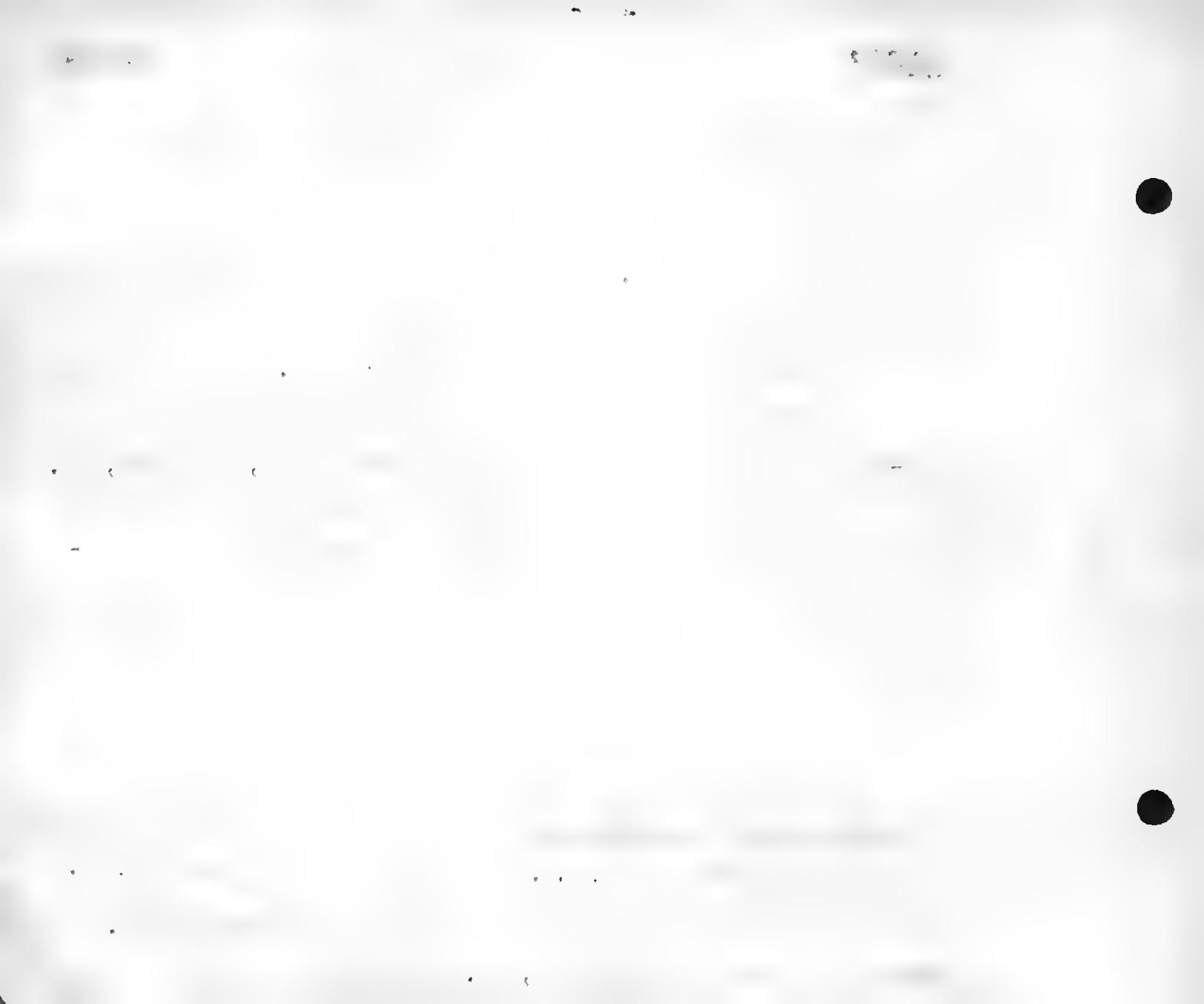
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14692

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14763

1. PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		b. COUNTY Allegany				
c LENGTH OF STAY IN b. Midland		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS				
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) PETER		First A.	Middle BRINER			
4. DATE OF DEATH 11/26/1967		Month 11	Day 19			
5. SEX Male		6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
8. DATE OF BIRTH 8/31/1894		9 AGE (In years last birthday) 73 yrs	10 IF UNDER MONTHS YEARS Days IF UNDER 24 HRS Hours Min			
10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Police Officer-Town of Midland		11 BIRTHPLACE (State or foreign country) Eckhart, Md.	12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter Briner		14. MOTHER'S MAIDEN NAME Magdalene Ellinger				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes-World War # 1		16. SOCIAL SECURITY NO	17. INFORMANT Address Miss Grace Briner, Midland, Md. (Daughter)			
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 42 ii DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden				
Coronary Occlusion		Coronary Sclerosis				
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		11/26/1967		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland, Md.	(County)	(State)
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR Charles J. George		25b. REGISTRAR'S SIGNATURE		
26. ATSMC (5) 6M 1/67		DATE NOV 28 1967				



FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. GIVE Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

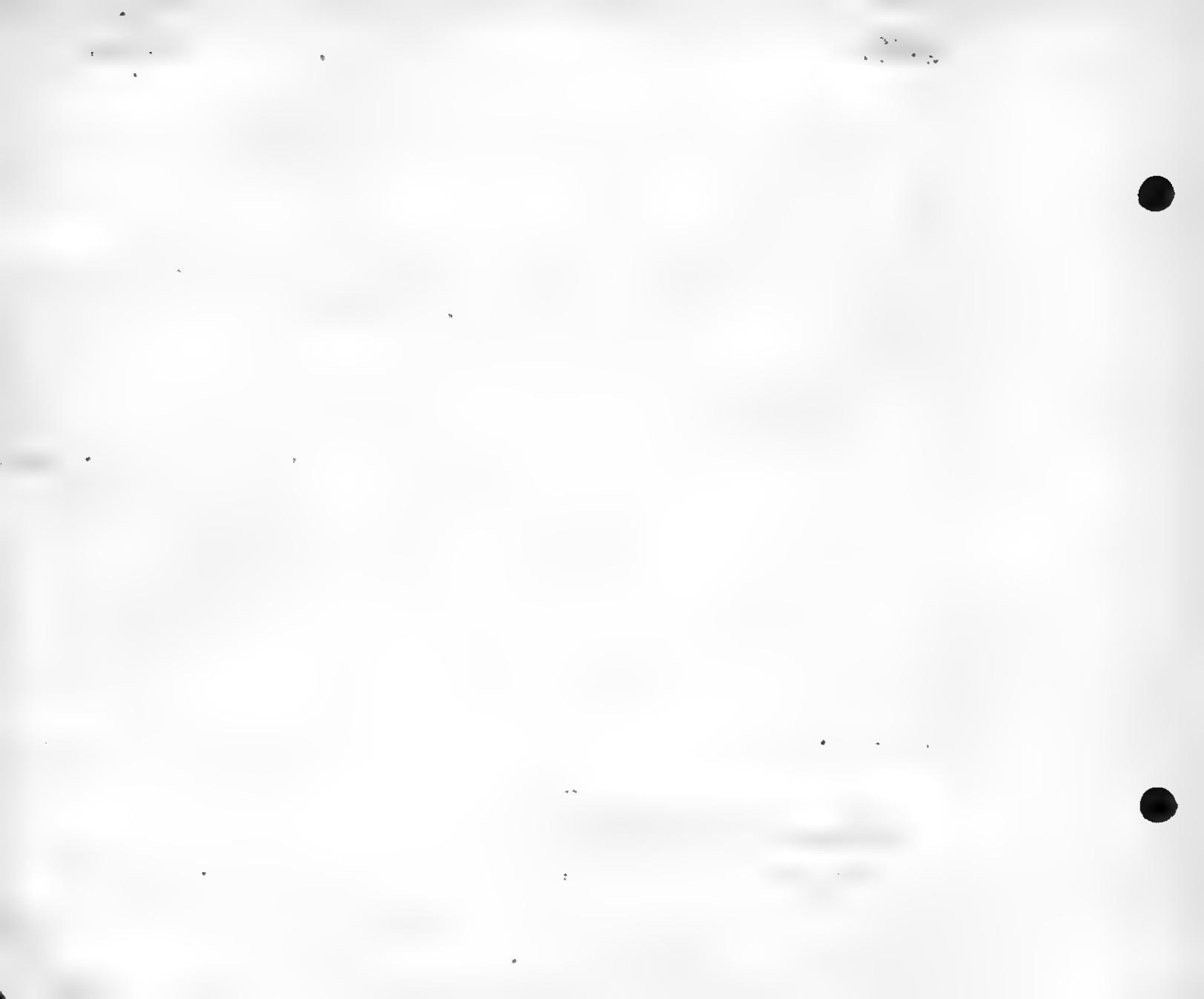
14693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14704

1 PLACE OF DEATH a. COUNTY Allegany			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b 81 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 501 Oldtown Road
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Miss Elizabeth Catherine Brinker		First Elizabeth	Middle Catherine	Last Brinker	4 DATE OF DEATH Month Nov. Day 3 Year 1967
S. SEX Female (F)	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 17, 1886	9 AGE (in years last birthday) yrs 81
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) Cumberland, Md.	
13 FATHER'S NAME Mathias Brinker			14. MOTHER'S MAIDEN NAME Louise Ruppenkamp		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIA. SECURITY NO		17 INFORMANT Address Mrs. Dorothy Roby, Cumberland, Md. Niece	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last Fracture of Right Tibia & Fibula (Pathologic) DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 29 Days		
20c TIME OF INJURY Month Day, Year Hour or m 10:00 Nov. 3 1967			20d INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg, etc.) Home	20f. (City or town) Cumberland, Allegany, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			22. DATE SIGNED Nov. 3, 1967		
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rt. 9 Cumberland		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 6, 1967	23c NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery	23d LOCATION (City or Town) Cumberland, Md.	(County) Allegany	(State)
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a REC'D BY REGISTRAR NOV 8 1967			
				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14694

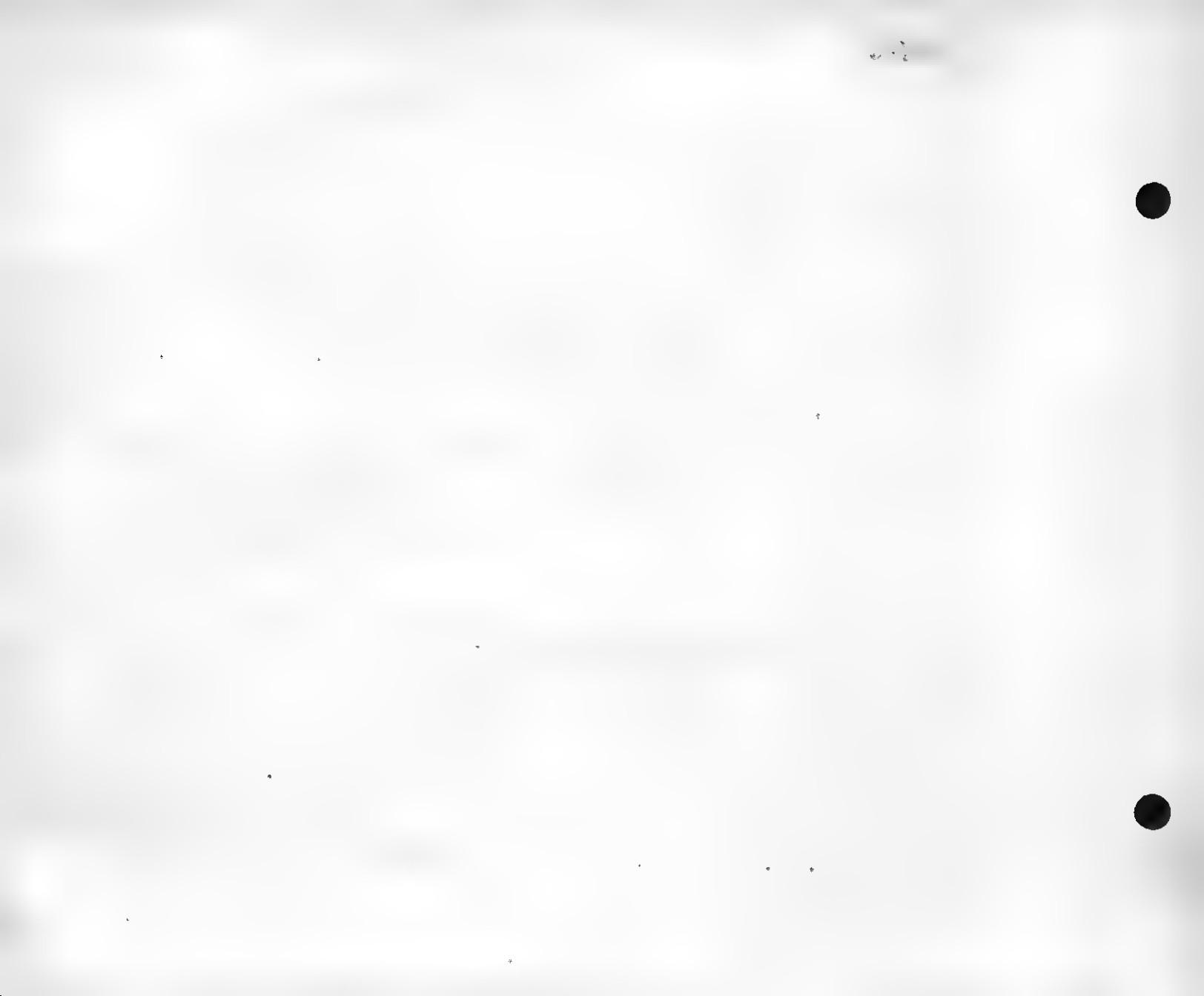
CERTIFICATE OF DEATH

14705

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 through 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 223 OFFUTT STREET		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)	First CALBERT	Middle	Last BUSSARD	
4 DATE OF DEATH	Month NOVEMBER	Day 19	Year 67	
5 SEX MALE	6 COLOR DR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-02	
9 AGE (In years lost since today) 65 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist Helper	11b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) BEDFORD, PA.	12. CITIZEN OF WHAT U. COUNTRY	
13. FATHER'S NAME BUSSARD, (Harold)	14. MOTHER'S MAIDEN NAME Unknown	Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 705-07-9643	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO <i>Diabetes Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerosis</i> DUE TO <i>Diabetes Mellitus</i> (c) <i>Arteriosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Cumberland, Md.</i> (County) <i>Calvert Co.</i> (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>11/6/67</i> to <i>11/7/67</i> , 19_____, and that death occurred at <i>9:05 P.M.</i> on <i>11/7/67</i> , 19_____, that (I) (we) last saw the deceased alive on <i>11/6/67</i> , 19_____, and that death occurred at <i>9:05 P.M.</i> on the date stated above.				
22. SIGNATURE <i>R. J. Williams</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11/6/67</i>	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Fellowship Cemetery	23d. LOCATION (City or Town) (County) (State) Centerville, Pa.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR NOV 8 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #ea Form # 23-12-76 (ph)												14786							
14695						CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE MARYLAND						b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN b 24 HOURS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			d. STREET ADDRESS Rt. 3 Union Grove Rd. P.O. BOX 133 Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						e. DATE OF DEATH NOV. 21 1967													
3. NAME OF DECEASED (Type or print) HOLMES		First H.		Middle CESSNA		3. SEX MALE		4. DATE OF DEATH NOV. 21 1967		5. IF UNDER 1 YEAR Months 66 Days 00 Hours 00 Min. 00		6. COLOR OR RACE WHITE		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-01		9. AGE (In years lost birthday) 66 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COTIN SHOP OWNER				11. KIND OF BUSINESS OR INDUSTRY COINS				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN C. CESSNA				14. MOTHER'S MAIDEN NAME JANE (HOUCK)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO 214-05-4006				17. INFORMANT HOSPITAL RECORD				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pulmonary edema DUE TO 4.232 INTERVAL BETWEEN ONSET AND DEATH 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) congestive heart failure DUE TO 1 month lost. (c) chronic myocarditis DUE TO 6 months																			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) chronic alcoholism, severe malnutrition												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 11-21-1967 (County) MD. (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-3- , 19 67 , to 11-21- , 19 67 , that (I) (we) last saw the deceased alive on 11-21-1967 , and that death occurred at M , from causes and on the date stated above												22b. DATE SIGNED 11-22-67							
22a. SIGNATURE L. Lewis						22b. ADDRESS DR. LEWIS BRINGS						22c. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 11/24/67				23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.				23d. LOCATION (City or Town) Cumberland, MD. (County) MD. (State)							
24. FUNERAL DIRECTOR Stein's Funeral Home				ADDRESS Cumb. MD.				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 25M 1/67				DATE NOV 27 1967															

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14696

14707

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b. COUNTY ALLEGANY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c LENGTH OF STAY IN TB 10 DAYS 6HRS	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND	d STREET ADDRESS APT 408 KENNEDY APTS IS RESIDENCE ON A FARM? MECHANIC STREET YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d DATE OF DEATH NOVEMBER 1, 1967			
3 NAME OF DECEASED (Type or print)	First MILO	Middle H	Last CLEM SR.		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1886	9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman		10b KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State or foreign country) Terre W. VIRGINIA Alta	
13. FATHER'S NAME JAMES CLEM		14. MOTHER'S MAIDEN NAME ISABELLE WILES		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Post operative-Intestinal Obstruction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days			
19. MEDICAL CERTIFICATION Old Age-Arteriosclerosis-Generalized: 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 21 1967, to Nov 1, 1967, that (I) (we) last saw the deceased alive on Oct. 21 1967, and that death occurred at 6:00 AM from causes and on the date stated above.		22b. DATE SIGNED 11-1-67			
22a. SIGNATURE DR. G. OVERTON HIMMELWRIGHT		22d ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 3, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Zion Memorial Cemetery	23d. LOCATION (City or Town) Cumberland, Md.	(County) Allegany (State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 25M 1/67					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14697

CERTIFICATE OF DEATH

14708

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DEANNA	Middle WILLIAMS	Last COLE
4. DATE OF DEATH	Month NOVEMBER	Day 11	Year 1967
S. SEX FEMALE	6. COLOR OR RACE NEGROE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH SEPT. 6, 1898	9. AGE (In years last birthday) 69 yrs	10. FUNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND	12. CIT ZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH WILLIAMS	14. MOTHER'S MAIDEN NAME JENNIE EDLONDSON	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.C. N.A.	
16. SOCIAL SECURITY NO. 215-18-8165-B		17. INFORMANT MR. ERNEST A. COLE, JR.	18. ADDRESS 115 SPRING
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage.</i>		INTERVAL BETWEEN ONSET AND DEATH 12 hr.	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Generalized atherosclerosis</i>		DUE TO (c) <i>Essential hypertension.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Obesity, extreme.</i>		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Nov. 11 1967	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJRY (Name, form, factory, street, office bldg, etc.) PARK	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from November 11 1967 to Nov. 11, 1967 , that (I) (we) last saw the deceased alive on Nov. 11 1967 , and that death occurred at 2:50 P.M. from causes and on the date stated above		22b. DATE SIGNED 11/14/67	
22a. SIGNATURE <i>Alvin J. Walters</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF NOV. 14, 1967		23c. NAME OF CEMETERY OR CREMATORIAL PARK FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR ARLOU M. SOWERS HAFER-SOWERS FUNERAL		25a. REC'D BY REGISTRAR NOV. 16 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
ADDRESS Maple M. Sowers Home, 60 W. MAIN, FROSTBURG			



FOR STATE
HEALTH DEPT.

2 and 3 to
PM Page

1
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office along with form PM Page 1.

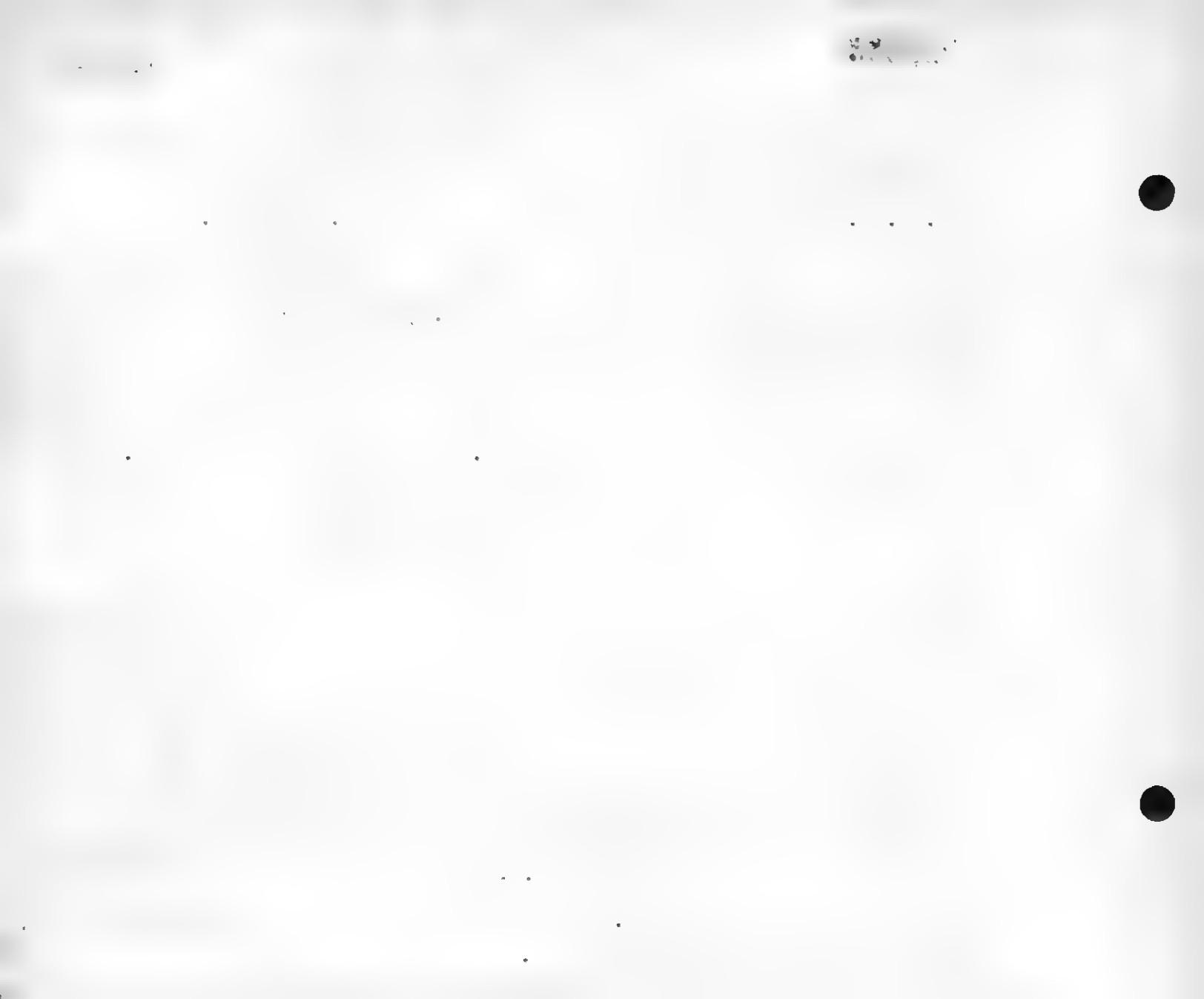
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14709

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 50 years	b. COUNTY Allegany	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		d. STREET ADDRESS 311 S. Cedar St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pete	First Pete	Middle Conis	Last Nov. 11 1967
4. DATE OF DEATH Oct. 5, 1896	Month Nov.	Day 11	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1896
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Calabria, Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Conis		14. MOTHER'S MAIDEN NAME Grace Gallizzi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO Mrs. Mary Conis, Cumberland, Md. Wife	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Coronary Occlusion lost		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO (b) Due to (c)		---	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town), (County), (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Nov. 11, 1967	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rt. 9 Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF ADDRESS	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City or Town) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	25a. RECD BY REGISTRAR NOV 14 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14710

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **ALLEGANY** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **CUMBERLAND**

c. LENGTH OF STAY IN lb **1 DAY**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **MARYLAND** b. COUNTY **ALLEGANY**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **CUMBERLAND**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL

d. STREET ADDRESS **2 A FT. CUMBERLAND HOME**

e. RESIDENCE
Is it a farm? **YES** **NO**

3. NAME OF DECEASED First **LEWIS** Middle **R.** Last **CRABTREE**

4. DATE OF DEATH Month **NOVEMBER** Day **6** Year **1967**

5. SEX **MALE** **6. COLOR OR RACE** **WHITE** **7. MARRIED** **NEVER MARRIED**
WIDOWED **DIVORCED**

8. DATE OF BIRTH **5-6-1889** **9. AGE (In years last birthday)** **78 yrs**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Orderly**

10b. KIND OF BUSINESS OR INDUSTRY **Hospital**

11. BIRTHPLACE (Country & State, or foreign country) **OLDTOWN, MD.**

12. CITIZEN OF WHAT COUNTRY **S. A.**

13. FATHER'S NAME **LEONARD S. CRABTREE**

14. MOTHER'S MAIDEN NAME **FANNIE MYERS**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service] **no**

16. SOCIAL SECURITY NO.

17. INFORMANT **MEMORIAL HOSPITAL, CUMBERLAND, MD.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CONGESTIVE HEART FAILURE** **INTERVAL BETWEEN ONSET AND DEATH** **?**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **ARTERIOSCLEROTIC HEART DISEASE** **?**

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

NONE

19. WAS AUTOPSY PERFORMED? **YES** **NO**

20a. ACCIDENT WAS UNDER. YING **OR CONTRIBUTING** **CAUSE OF DEATH** **(If either, notify medical examiner)**

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. **19** **20d. INJURY OCCURRED**
p.m. **19** While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **11-6-1967** **to** **8:30 A.M. 6-19-67** **that (I) (we) last saw the deceased alive on** **11-6-1967** **and that death occurred at** **8:30 A.M.** **from causes and on the date stated above**

22a. SIGNATURE *Thomas Lusby*

22b. DATE SIGNED **11/6/67**

22c. PHYSICIAN'S NAME (Type) **DR. THOMAS LUSBY**

22d. ADDRESS **CAVALE, MD.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

23b. DATE THEREOF **Nov. 9, 1967**

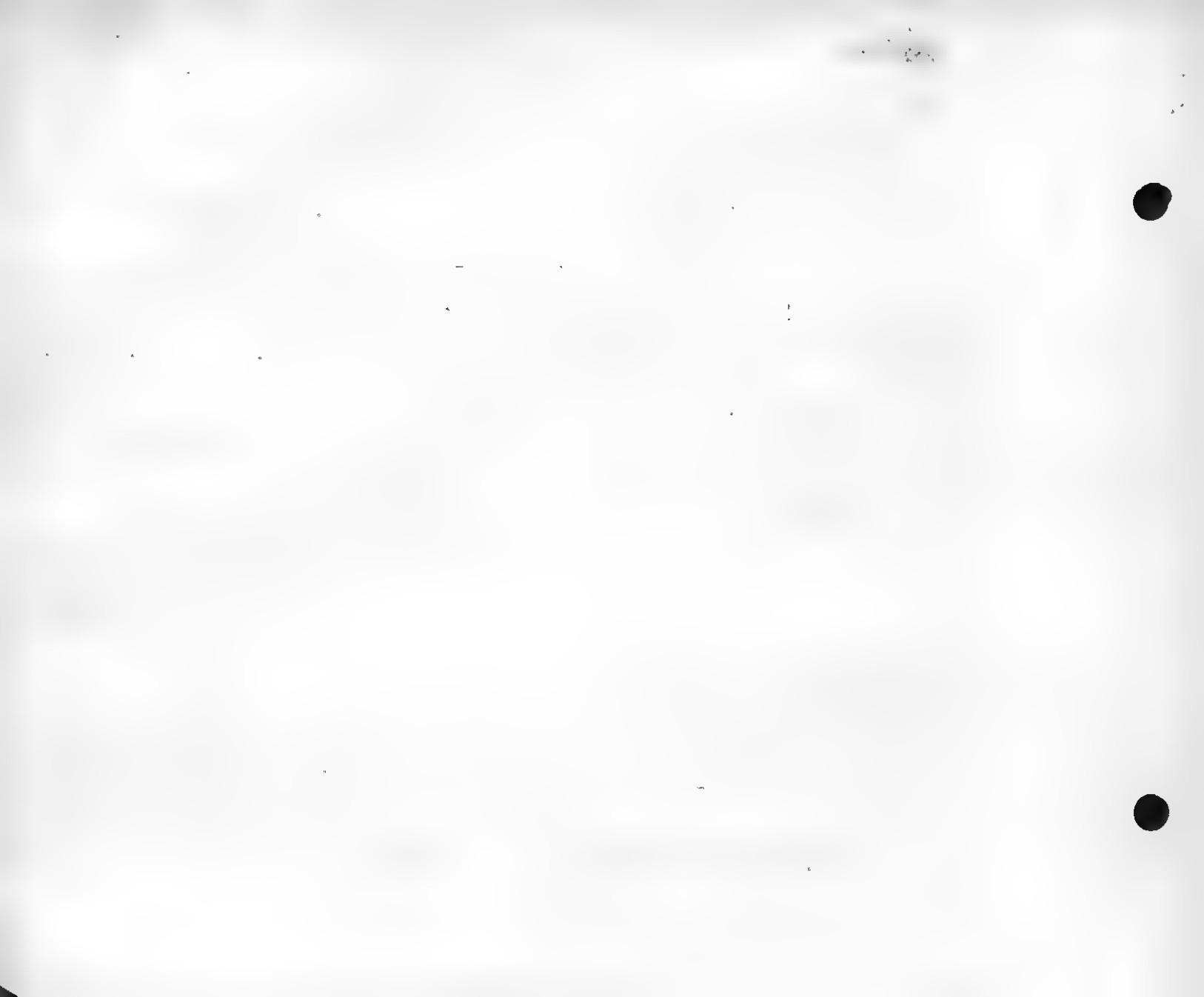
23c. NAME OF CEMETERY OR CREMATORIAL **Hillcrest Burial Park**

23d. LOCATION (City or Town) (County) (State) **Cumberland, Md. Allegany**

24. FUNERAL DIRECTOR **James F. Scarpelli, Cumberland, Md.**

25a. REC'D BY REGISTRAR **DAW 01 10 1967**

25b. REGISTRAR'S SIGNATURE *Charles Judge*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

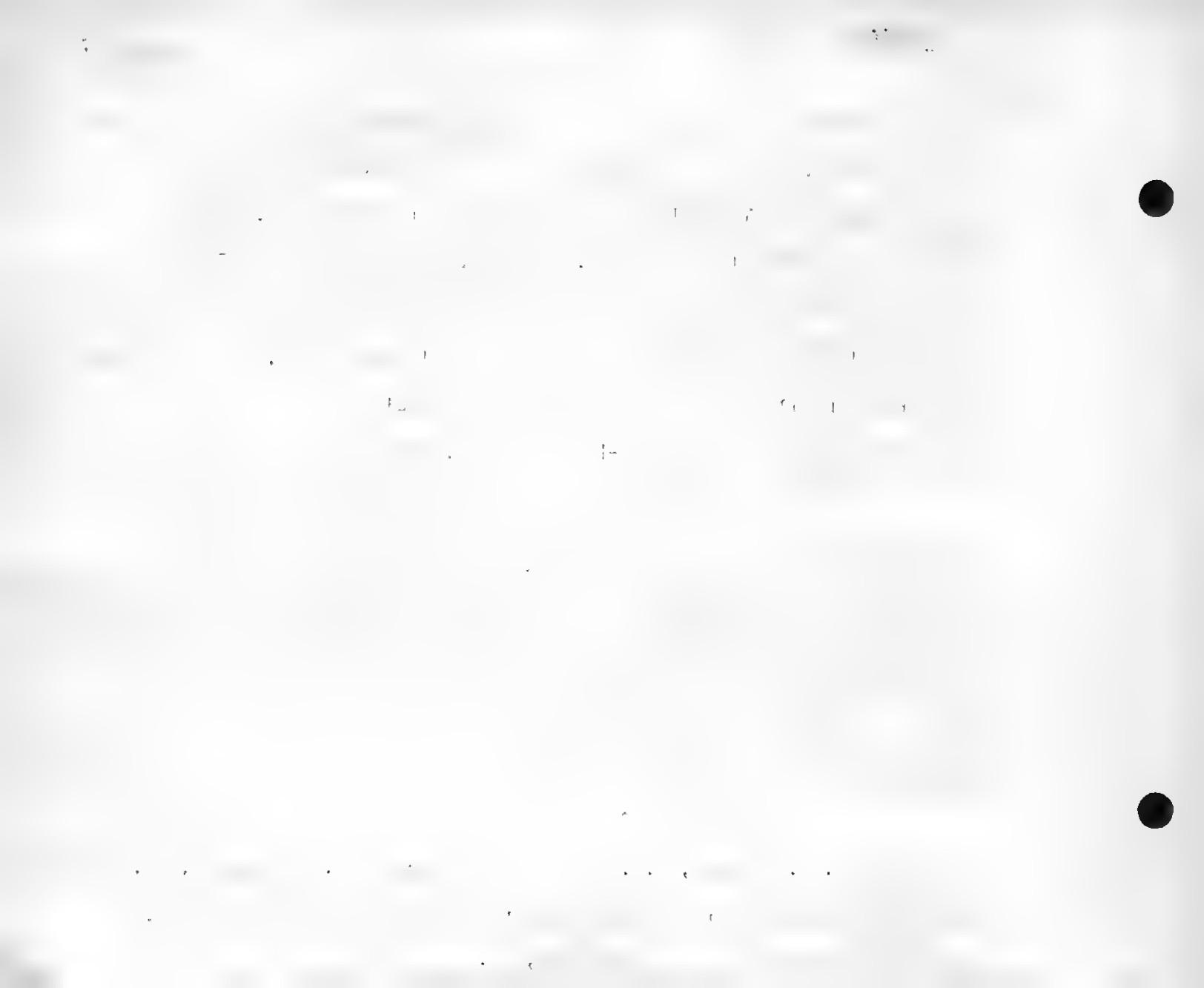
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14700

CERTIFICATE OF DEATH

14711

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 23 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 126 ORMOND ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LORRAINE	Middle A.	Last CULLEN
4. DATE OF DEATH Month NOVEMBER	Day 26	Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-27
9. AGE (In years last birthday) 40 yrs	10. UNDER 1 YEAR Months 3	11. UNDER 24 HRS Days 0	12. HOURS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) KITZMILLER, MD.	
13. FATHER'S NAME PETER PRATT		14. MOTHER'S MAIDEN NAME SICOLI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 212-24-1825	17. INFORMANT HOSP. RECORD	Address
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DIABETIC NEPHROSCLEROSIS		DUE TO (b) DIABETES	4 YEARS
		DUE TO (c) DIABETES	17 YRS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE HEART DISEASE C HEART FAILURE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (1) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (1) we) ast saw the deceased alive on 11/25 1967 , and that death occurred at 11/26 1967 M, from causes and on the date stated above.		22b. DATE SIGNED 11/26/67	
22a. SIGNATURE S. G. WEISMAN		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS 59 GREENE ST. CUMBERLAND, MD. 21502
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 29 1967	23c. NAME OF CEMETERY OR CREMATORIUM ST. MICHAEL'S CEMETERY
24. FUNERAL DIRECTOR DURST FUNERAL HOME		25a. RECEIVED BY REGISTRAR DATE DEC. 1 1967	25b. REGISTRAR'S SIGNATURE Charles S. Weisman
VR A15 (4) 25M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14701

CERTIFICATE OF DEATH

14712

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN lb <i>66 Yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		d. STREET ADDRESS <i>825 Braddock Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>825 Braddock Road, Cumberland, Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rebecca		First Jeannette	Middle Dantzic
4. DATE OF DEATH 11 - 15 - 1967	Month	Day	Year
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-4-1901
8. OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		9. AGE (In years last birthday) 66 yrs	
10a. KIND OF BUSINESS OR INDUSTRY Pianoist		11. BIRTHPLACE (County & State, or foreign country) Cumberland Allegany, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Jacob Dantzic	
14. MOTHER'S MAIDEN NAME Celia (Batnick)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 220-16-5955		17. INFORMANT Dr. Ethyl Dantzic	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1960</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>Carcinoma of Colon cured metastasis.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-4-63 , 19 to 11-5- , 1967, that (I) (we) last saw the deceased alive on 11-5 1967, and that death occurred at 245 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Clarence J. Vincent</i>		22b. DATE SIGNED 11-6-67	
22c. PHYSICIAN'S NAME (Type) Dr. Clarence J. Vincent		22d. ADDRESS 124 N. Smallwood St., Cumb., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-67	23c. NAME OF CEMETERY OR CREMATORIAL East View Cemetery
24. FUNERAL DIRECTOR H. Lee Silcox		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Md.	
		25a. RECEIVED BY REGISTRAR NOV 9 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14713

FOR STATE
HEALTH DEPT.

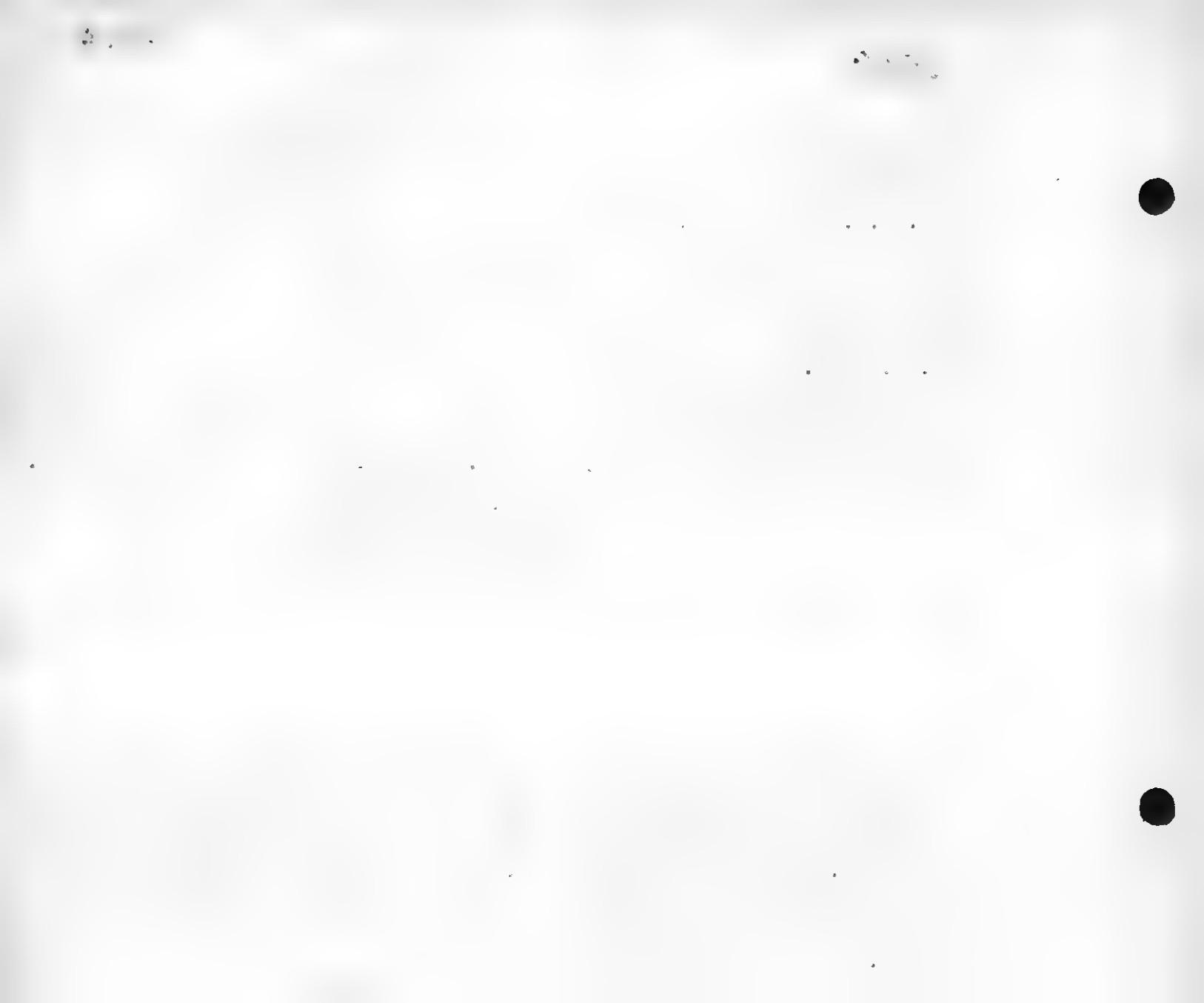
14702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b. 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O.A. Memorial Hospital		e. 3. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas		First Arner Dentinger	Middle Last
4. DATE OF DEATH Nov. 10 1967	Month Nov.	Doy 10	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 16, 1909	9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. A. Dept.		10b. KIND OF BUSINESS OR INDUSTRY Textile Ind.	
11. BIRTHPLACE (State or foreign country) Weissport, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Dentinger		14. MOTHER'S MAIDEN NAME Hazel Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO 214-07-5150	
17. INFORMANT Mrs. Lillie Dentinger, Cumberland, Md.		Address Wife	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Coronary Occlusion			
Coronary Sclerosis		---	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		22. DATE SIGNED Nov. 10, 1967	
		Address (Street, city, town, or county) Rt. 9 Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
23d. LOCATION (City or Town) Cumberland Allegany Md.		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR NOV 14 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14714

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANCIS		4. DATE OF DEATH Month NOVEMBER Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1898 11-26-1898 (68 yrs)
9. AGE (In years months days)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) SOMERSET CO. PA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Christian Dick		14. MOTHER'S MAIDEN NAME Elizabeth Hedrick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 705-05-4452	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 10 hrs Acute myocardial infarction	
(b) DUE TO Generalized arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 1967, to <u>Nov. 14, 1967</u> , 1967, that (I) (we) last saw the deceased alive on <u>11-11-1967</u> , and that death occurred at <u>M</u> , from causes and on the date stated above			
22a. SIGNATURE <u>William P. James</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22b. DATE SIGNED 11/14/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 14, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 16 1967 DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT

Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5, may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14704

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14715

1 PLACE OF DEATH a. COUNTY Allegany			2 USUAL RESIDENCE (Where deceased resided, if institution residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Rawlings		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.			e. STREET ADDRESS Along U. S. Rt. # 220		
3. NAME OF DECEASED (Type or print) Melvin Leroy Dixon			f. DATE OF DEATH November 13, 1966		
4. SEX Male	5. COLOR OR RACE White	6. MARRIED W DIVORCED	7. NEVER MARRIED DIVORCED	8. DATE OF BIRTH Dec. 30, 1966	9. AGE (In years at birth/day) 10 months 14 days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (infant)			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) Cumberland, Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Melvin L. Dixon, Sr.			14. MOTHER'S Maiden Name Theresa Grogg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No,			16. SOCIAL SECURITY NO None		
17. INFORMANT Mr. Melvin L. Dixon, Sr., Rawlings, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7543 DUE TO Conditions, f. o. w. ch gave rise to immediate cause (a) stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH Hours Acute Cardiac Failure; Hydrothorax; --- Congenital Anomalies of Heart (Patent foramen ovale; Patent ductus arteriosus; Aortic Stenosis) --- ---		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 11/13/67 Rt. # 9 Cumberland, Md.					
22. DATE SIGNED					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Benedict Skitarelic		23a. BURIAL CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11/16/67 23c. NAME OF CEMETERY OR CREMATORIUM Waxler Cemetery 23d. LOCATION (City or Town) (County) (State) Dawson, Allegany Maryland			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. ADDRESS ADDRESS 25b. REGISTRAR'S SIGNATURE DATE NOV 17 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages _____
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

CERTIFICATE OF DEATH												14716			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND									
b. CITY OR TOWN (If outside corporate limits, give name of town) CUMBERLAND			c. LENGTH OF STAY IN lb 2 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE			d. COUNTY ALLEGANY						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First VERNELDA	Middle G.	Lost DONAHOE	4. DATE OF DEATH NOV. 19, 1967	Month	Day	Year	5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1912	9. AGE (In years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE			11. BIRTHPLACE (County & State or foreign country) PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME ALFRED BENNETT						14. MOTHER'S MAIDEN NAME MARY TWIGG									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO NONE				17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intraepithelial Ca - lung, Skin, Bone</i> DUE TO <i>7 yr.</i> (b) <i>Akanso Ca of left breast</i> DUE TO <i>2-3 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) 1965		(County) PA.		(State) PA.			
21. I certify that (I) (this hospital) attended the deceased from Jan 1967 , to 10:00 A.M. , 19____, that (I) (we) last saw the deceased alive on Nov 19 1967 , and that death occurred on Nov 19 1967 M, from causes and on the date stated above															
22a. SIGNATURE <i>J. Mirkin</i>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS 115 S. CENTRE ST. CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 22 1967		23c. NAME OF CEMETERY OR CREMATORIAL SEVEN DOLORS CATHOLIC CEMT.		23d. LOCATION (City or Town) (County) (State) BEANS COVE, BLOUFORD PA.									
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND, MD.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Lee Silcox</i>									
DATE NOV 22 1967															



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14706

CERTIFICATE OF DEATH

14717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Direct all correspondence to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN lb 20 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	d. STREET ADDRESS RT 4 BOX 299
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIE	First MIDDLE	Lost DUVALL	4. DATE OF DEATH NOVEMBER 27 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH 4-22-01	9. AGE (In years lost birthday) 66 yrs
13. FATHER'S NAME THOMAS MIDDLETON	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MOTHER'S MAIDEN NAME LAURA TWIGG
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 219-46-1956	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2040 DUE TO Chronic lymphatic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 3 months	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. PLACE OF INJRY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) CUMBERLAND	(County) ALLEGANY
21. I certify that (I) (this hospital) attended the deceased from 11/17/67 , 19 6:40 P.M. , 19 67 , that (I) (we) last saw the deceased alive on 11/17/67 , 19 67 , and that death occurred at CUMBERLAND , MD, from causes and on the date stated above.	22b. DATE SIGNED 11/28/67		
22c. PHYSICIAN'S NAME (Type) DR. I. DROSS	M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/30/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Tabor Methodist Cemetery	23d. LOCATION (City or Town) (County) (State) Allegany County Md.
24. FUNERAL DIRECTOR John J. Hafer	25a. ADDRESS John J. Hafer, Jr., 230 Balto' Ave. Cumberland, MD	25b. REC'D BY REGISTRAR DEC 4 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14707

CERTIFICATE OF DEATH

14718

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in b the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN b LIFE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 256 E. MAIN STREET		e. STREET ADDRESS 256 E. MAIN STREET				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) F. MEILVIN	First	Middle	4. DATE OF DEATH Month NOVEMBER			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH JULY 12, 1894	10. AGE (In years days months years)	11. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY P.B.G.H. PLATE GLASS		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK R. EICHORN		14. MOTHER'S MAIDEN NAME SOPHIA REIDLER		Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W/1		16. SOCIAL SECURITY NO 220-10-7466		17. INFORMANT MRS. ELIZABETH EICHORN, FROSTBURG, MD.		18. INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Carcinoma Liver & Stomach Generalized arteriosclerosis & Arteric Disease				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1967 to Nov 10, 1967 that (I) (we) last saw the deceased alive on Nov 9, 1967 and that death occurred at 4th M. from causes and on the date stated above						
22a. SIGNATURE <i>John B. Davis, M.D.</i>		22b. DATE SIGNED 11/10/67				
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-13-67		23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR J.C. EPH R. DURST, SR., FROSTBURG, MD. 21532		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 14 1967		25b. REGISTRAR'S SIGNATURE <i>Glenda Judge</i>



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14719
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN lb 8 days				b. COUNTY Allegany				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miner's Hospital				d. STREET ADDRESS 139 East Mechanic Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO XX				
3. NAME OF DECEASED (Type or print) Thomas J Eisentruit			First	Middle	Last	4. DATE OF DEATH November 12 1967	Month	Day	Year			
S SEX Male	6. COLOR OR RACE White	7. MARR ED WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-31-82	9. AGE (In years last birthday) 86 85 yrs	IF UNDER 1 YEAR Months 86 85 yrs	IF UNDER 24 HRS Days 86 85 yrs	IF UNDER 24 HRS Hours 86 85 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner			10b. KIND OF BUSINESS OR INDUSTRY Mines			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Eisentruit						14. MOTHER'S MAIDEN NAME Mary Ann Fee						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			6. SOCIAL SECURITY NO 214-01-3649-A			17. INFORMANT Miner's Hospital, Frostburg, Maryland			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)						Pulmonary Embolism, Massive Comminuted Fracture Left Radius						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH Days						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell at home in his yard									
20c. TIME OF INJURY Month, Day, Year - Hour 3:00 p.m Nov. 3 1967			20d. INJURY OCCURRED While <input type="checkbox"/> At work <input checked="" type="checkbox"/> Nat While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Yard at Home			20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) Yard at Home			20f. (City or town) (County) (State) Frostburg, Allegany, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.												
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 15 '67		23c. NAME OF CEMETERY OR CREMATORIUM Fbg. Memorial Park				23d. LOCATION (City or Town) (County) (State) Frostburg, Md. 21532				
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 17 1967				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14720

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2 CUMBERLAND MARYLAND		c LENGTH OF STAY IN b 59 YRS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD 2 CUMBERLAND, MD.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARION MONROE FEY		First Middle Last	4 DATE OF DEATH Month Day Year NOV 12 19 67
S SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 23, 1908
9 AGE (In years last birthday) 59 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTEL OWNER		10b KIND OF BUSINESS OR INDUSTRY MOTEL	
11 BIRTHPLACE (State or foreign country) CRESAPTOWN, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Gibson JAMES BENEDICT STARKEY		14 MOTHER'S MAIDEN NAME BERTHA (McBEE) STARKEY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 214-05-7711	
17 INFORMANT MR. GEORGE C. FEY SR.		18 INTERVAL BETWEEN ONSET AND DEATH Sudden	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Coronary Sclerosis		20 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. ---	
20a EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CUMBERLAND, MARYLAND
20f (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED November 12, 1967			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) CUMBERLAND, MARYLAND	
23c BURIAL CREMATION REMOVAL (Specify) BURIAL		23b DATE THEREOF 14 NOV 67	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		25a ADDRESS 25b REC'D BY REGISTRAR DATE NOV 14 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14710

CERTIFICATE OF DEATH

14721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
3 NAME OF DECEASED (Type or print) CLIFTON		d. STREET ADDRESS 70 S. WATER STREET	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JULY 14, 1883		9. AGE (In years last birthday) 84 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GEIS		14. MOTHER'S MAIDEN NAME JULIA LAPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-22-3099	
17. INFORMANT Mrs. MILDRED COAKLEY, FROSTBURG, MD.		Address 14 W. MAIN ST.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis - generalized		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJRY Month, Day, Year Hour o.m. p.m. 19		20d. INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJRY (Home farm factory, street, office bldg, etc.) factory
20f. (City or town) FROSTBURG		(County) (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from Nov. 20, 1962 , to Nov. 26, 1967 , that (I) (we) last saw the deceased alive on Nov. 26 1967 , and that death occurred at 10:30 PM , from causes and on the date stated above.			
22a. SIGNATURE G. Miles Jr.		22b. DATE SIGNED 11-28-67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR. M.D.		22d. ADDRESS HONA CONING MD 21539	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 29 1967	23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DEC 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Jader	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14722

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ALLEGANY			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN b. DOA MEMORIAL		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA MEMORIAL HOSPITAL			e. STREET ADDRESS 22 MARION STREET		
3 NAME OF DECEASED (Type or print) ROBERTA			First ROBERTA	Middle VIRGINIA	Last GOLDEN
4 DATE OF DEATH NOV. 22 1967	Month NOV.	Day 22	Year 1967		
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED X	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH FEB. 22, 1895	9 AGE (In years at birthday) 72 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		Ob. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11 BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
13 FATHER'S NAME ROBERT C. STOTLER			14 MOTHER'S MAIDEN NAME VIRGINIA "DRAKE" STOTLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT MR. D. HUGO GOLDEN 22 MARION ST. CUMBERLAND			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
Coronary Occlusion			Coronary Sclerosis		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) CUMBERLAND (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 22, 1967 Address (Street, city, town or county) CUMBERLAND, MARYLAND		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			22. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (specify) BURIAL		23b. DATE THEREOF 25 NOV 67	23c. NAME OF CEMETERY OR CREMATORIUM HILLCREST BURIAL PARK		23d. LOCATION (City or town) (County) CUMBERLAND ALLEGANY MARYLAND (State)
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST., CUMBERLAND MD.		ADDRESS H. Lee Silcox 404 Decatur St., Cumberland MD.	25a. REG'D BY REGISTRAR DATE NOV 27 1967		25b. REGISTRAR'S SIGNATURE <i>Marie Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14723

14712

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN MD 42 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 404½ N. CENTRE STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) LUCY		First H. Middle	4 DATE OF DEATH Month 11 Doy 24 Year 1967
5 SEX FEMALE		6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALES LADY		10b KIND OF BUSINESS OR INDUSTRY DEPT. STORE	8 DATE OF BIRTH 06-07-94
9 AGE (In years lost birthday) 73 yrs		11. BIRTHPLACE (County & State or foreign country) WALES, GREAT BRITAIN	12 CIT ZEN OF WHAT COUNTRY? ENGLAND
13. FATHER'S NAME ISAAC HALE		14. MOTHER'S MAIDEN NAME GRACE (BAILY)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 219-03-9979	17. INFORMANT HOSPITAL RECORD
		Address 900 SETON DRIVE., CUMB	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>M multiple Myeloma</i>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause b. c. d. e.		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		DUE TO	
20a ACC DENT WAS UNDER. YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1965</i> to <i>Nov. 1967</i> , that (I) (we) last saw the deceased alive on <i>11-23 1967</i> , and that death occurred at <i>9:03 AM</i> , from causes and on the date stated above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <i>Wayne C Spiegel + M Glick</i>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>11/24/67</i>
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK		22d. ADDRESS 126 N. SMALLWOOD STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 26-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL PARK <i>Frostburg Memorial Park</i>
24. FUNERAL DIRECTOR DURST FUNERAL HOME-57 FROST AVE., FROST., MD		23d. LOCATION (City or Town) <i>FROSTBURG, MD.</i>	(County) (State)
		25a. REC'D BY REGISTRAR DATE <i>NOV 28 1967</i>	25b. REGISTRAR'S SIGNATURE <i>DR. Wayne C. Spiegel</i>



2
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14713
CERTIFICATE OF DEATH

14724

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the hospital or attending physician, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b. 8/26/1966	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 77 Douglas Avenue	
e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jessie	Middle T.	Last Greene
4. DATE OF DEATH Month November	Day 8,	Year 1967	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 8/9/1873	9. AGE (In years last birthday) 94 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Louisville, Kentucky	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Trezise	14. MOTHER'S MAIDEN NAME Martha Eden		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO <i>Chronic A&C.V.D.</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) <i>many years.</i> DUE TO (c) <i>Generalized arterio sclerosis many years.</i>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic bronchitis</i> - <i>Diabetes mellitus</i>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/26/1966 to 11/8/1967 , that (I) (we) last saw the deceased at 11/8/1967 at 7:55 A.M. from causes and on the date stated above	22b. DATE SIGNED 11/8/1967		
22a. SIGNATURE <i>John A. Copper</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) John A. Copper, Jr.	22d. ADDRESS Memorial Hospital, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/11/1967	23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Lonaconing
24. FUNERAL DIRECTOR George Eickhorn, Lonaconing	ADDRESS George Eickhorn, Lonaconing	25a. REC'D BY REGISTRAR DATE NOV 13 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14725

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Marys, Maryland	
d. LENGTH OF STAY IN lb 90A		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
4. DATE OF DEATH		Month	Day Year
		Oct	17 1967
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH
			Oct. 17, 1967
9. AGE (In years lost birthday) yrs.		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert Gutierrez		Alice Martinez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
1542 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Edema, Hydrothorax, Purpuric Skin Eruption		DUE TO	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/67	23c. NAME OF CEMETERY OR CREMATORIAL St. Ann's Cemetery
24. FUNERAL DIRECTOR Burk Newmark		ADDRESS	23d. LOCATION (City or Town) (County) (State) R.D. Lanigan-Garrett
VR A15ME (5) 6M 1/67		25a. REC'D BY REGISTRAR NOV 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14726

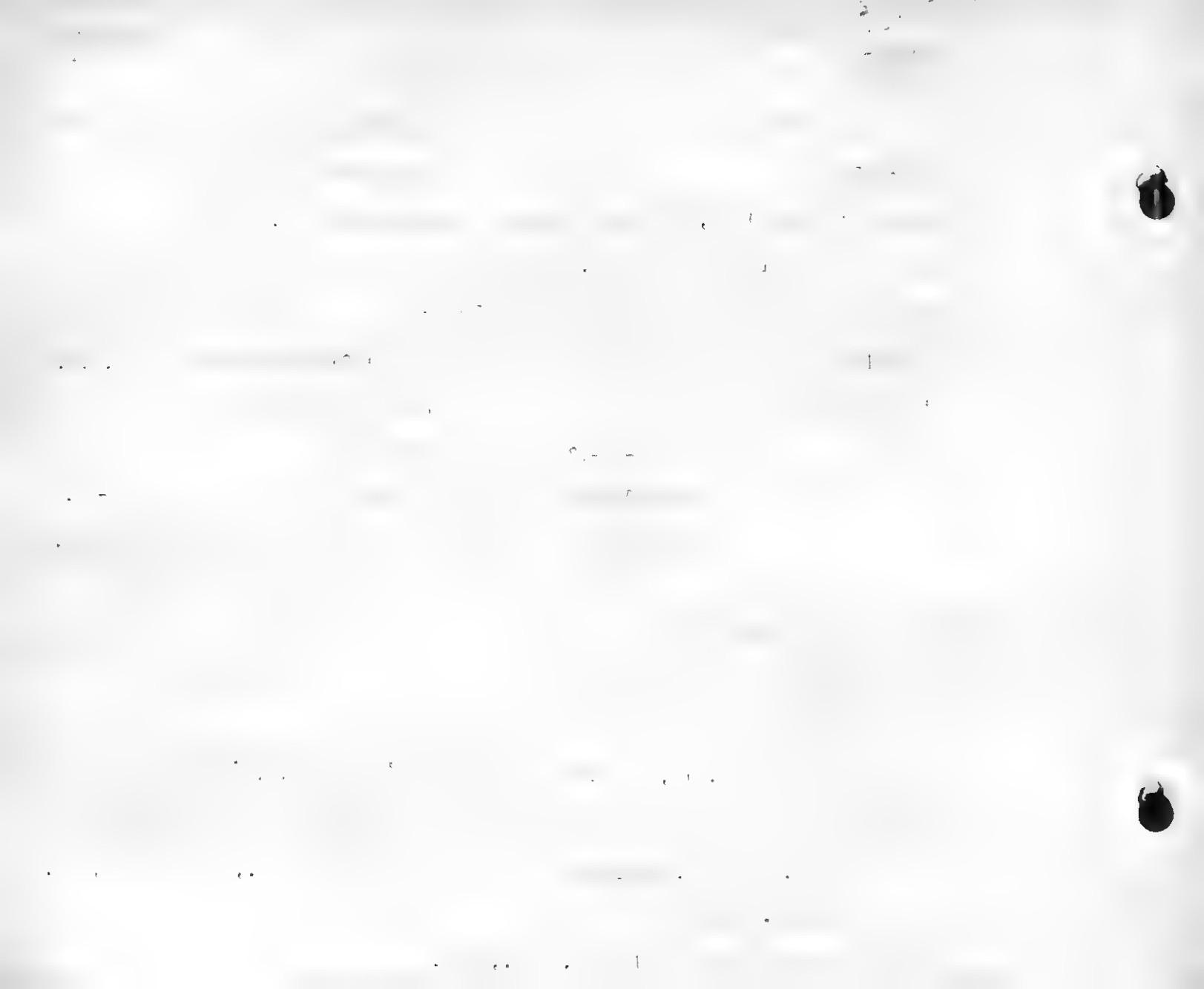
14715

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL, 900 SETON DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ESTELLA	Middle E.	Last HINER
4. DATE OF DEATH Month NOVEMBER	Day 17	Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-20-02
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years past birthday) yrs 65
13. FATHER'S NAME JAMES MESSICK		14. MOTHER'S MAIDEN NAME IDA MAE RODERICK	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 220-34-1326	17. INFORMANT Address HOSPITAL RECORD
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CACHEXIA DUE TO (c)			
INTERVAL BETWEEN PMS/AN DEATH 6 MO.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from APRIL 28, 1967 to NOV. 17, 1967 , that (I) (<input checked="" type="checkbox"/> X) last saw the deceased alive on NOV. 17, 1967 , and that death occurred at 9:30 A.M. M, from causes and on the date stated above.			
22a. SIGNATURE <i>James P. Hallinan M.D.</i>		22b. DATE SIGNED 11-18-67	
22c. PHYSICIAN'S NAME (Type) DR. JAMES P. HALLINAN		22d. ADDRESS 140 BEDFORD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 20, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Herman Cemetery
23d. LOCATION (City or Town) Cumberland Allegany, Md.		(County) (State)	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME		ADDRESS 108 VA. AVE., CUMB.	25a. REC'D BY REGISTRAR DATE NOV 27 1967
			25b. REGISTRAR'S SIGNATURE <i>James J. Scarpell</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 74 FROST AVENUE		e. STREET ADDRESS 74 FROST AVENUE	
3. NAME OF DECEASED (Type or print) F. JOSEPHINE		First HOLBEN	Middle JOSEPHINE
4. DATE OF DEATH NOVEMBER 27, 1967	Month NOVEMBER	Doy 27	Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 12, 1876	9. AGE (In years lost birthday) 91 yrs	10. KIND OF BUSINESS OR INDUSTRY MARYLAND	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME JOHN S. METZGER	14. MOTHER'S MARRIED NAME FLORENCE KELLER	15. INFORMANT MRS. RICHARD HOLBEN, FROSTBURG, MD.
16. SOCIAL SECURITY NO.			
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>arterio-sclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH 44 X DUE TO <i>Hypertension</i> 15 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> (c) <i>Hemiplegia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchial asthma</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) FROSTBURG (County) W. MAIN ST., FROSTBURG, MD. (State)			
21. I certify that (I) (This hospital) attended the deceased from 9-10 , 19 52 , to 11-27 , 19 67 , that (I) (we) last saw the deceased alive on 11-22 1967 , and that death occurred at 54 M, from causes and on the date stated above.			
22. SIGNATURE <i>H.C. Diehl</i>		22b. DATE SIGNED 11-28-67	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.		22d. ADDRESS W. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 30 '67	23c. NAME OF CEMETERY OR CREMATORIAL PARK FBG. MEMORIAL PARK
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		24. ADDRESS 21532	25a. REC'D BY REGISTRAR OCT 1 1967
			25b. REGISTRAR'S SIGNATURE <i>Alberto J. G.</i>

4
100



FOR STATE
HEALTH DEPT.

14717

14717
State Department of
Health

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14728

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Allegany

Md. IX

b. LENGTH OF STAY IN TB

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

McJulien Hwy

d. NAME

OR INSTITUTION (If not in hospital, give street address)

Homes R.F.D. Box 36 Rawlings

3. NAME OF
DECEASED
(Type or print)

Virginia

Rose

House

S. SEX

6. COLOR OR RACE

Female White

7. MARRIED

WIDOWED

DIVORCED

NEVER MARRIED



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b minutes	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Richard	Middle Leo	Last Howard, Sr.	4. DATE OF DEATH Month Nov. 18	Day 1967	Year					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1902	9. AGE (in years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 5 months	IF UNDER 24 HRS. Days 1 day	Hours 0 hours	Min. 0 minutes		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die-caster Operator		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (County & State, or foreign country) Garrett-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James G. Howard		14. MOTHER'S MAIDEN NAME Martha O'Meal									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-09-1754A		17. INFORMANT Ada Howard-Bloomington, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2 hours	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on Nov. 18 1967 , and that death occurred at 1:30 M, from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <i>J.H. Wolverton Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Piedmont, W.Va.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/67		23c. NAME OF CEMETERY OR CREMATORIAL Bloomington		23d. LOCATION (City, town or county) Bloomington		(State) Md.			
24. FUNERAL DIRECTOR <i>J. Bral</i>		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR NOV 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE			



FOR STATE
HEALTH DEPT.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death
necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

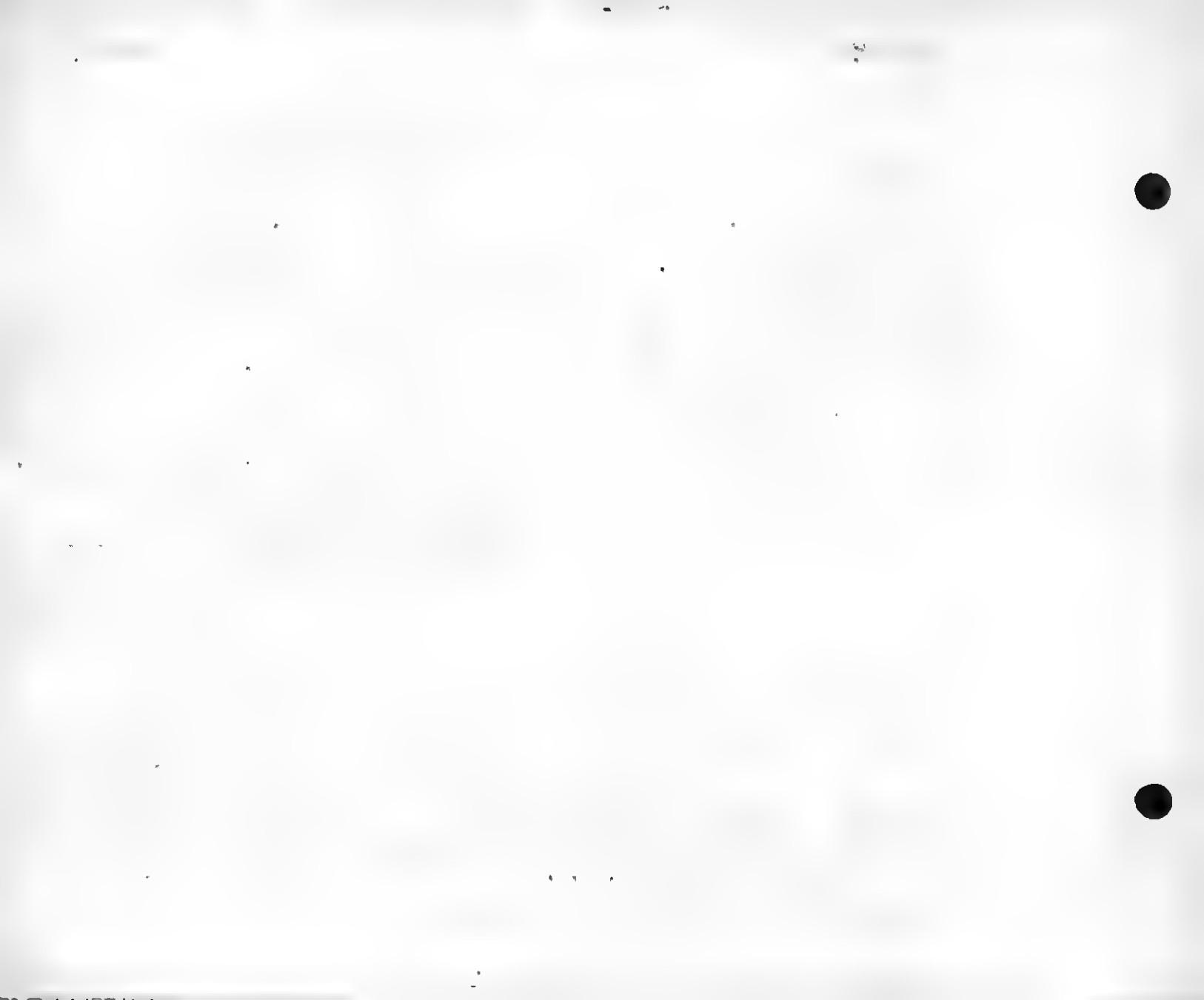
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14715

14730

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)	
a COUNTY Allegany MARYLAND		b STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
c LENGTH OF STAY IN lb		d STREET ADDRESS Douglas Ave.	
d. NAME OF HOSPITAL OR INST TUITION (If not in hospital, g ve street address) Douglas Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First JAMES W. MIDDLE HUTCHESON		4 DATE OF DEATH Month 11/14/1967 Day Year 19	
SEX Male COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH Month 11/25/1899 Year 1899	
WIDOWED <input checked="" type="checkbox"/> DIVORCED		9 AGE (In years lost birthday) yrs. 68	
10b USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired-County Road Employee		11 BIRTHPLACE (State or foreign country) Lonaconing, Md.	
13 FATHER'S NAME John Hutcheson		14. MOTHER'S MAIDEN NAME Bessie De Vault	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address William Hutcheson, Lonaconing, Md. (SON)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to Coronary Occlusion (INTERVAL BETWEEN ONSET AND DEATH Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to Coronary Sclerosis (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.M. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 11/14/1967	
ACTUAL SIGNATURE Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/1967	
23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR GEORGE EICHORN Lonaconing, Md.		25a. REC'D. BY REGISTRAR NOV 20 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE		Signature	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14780

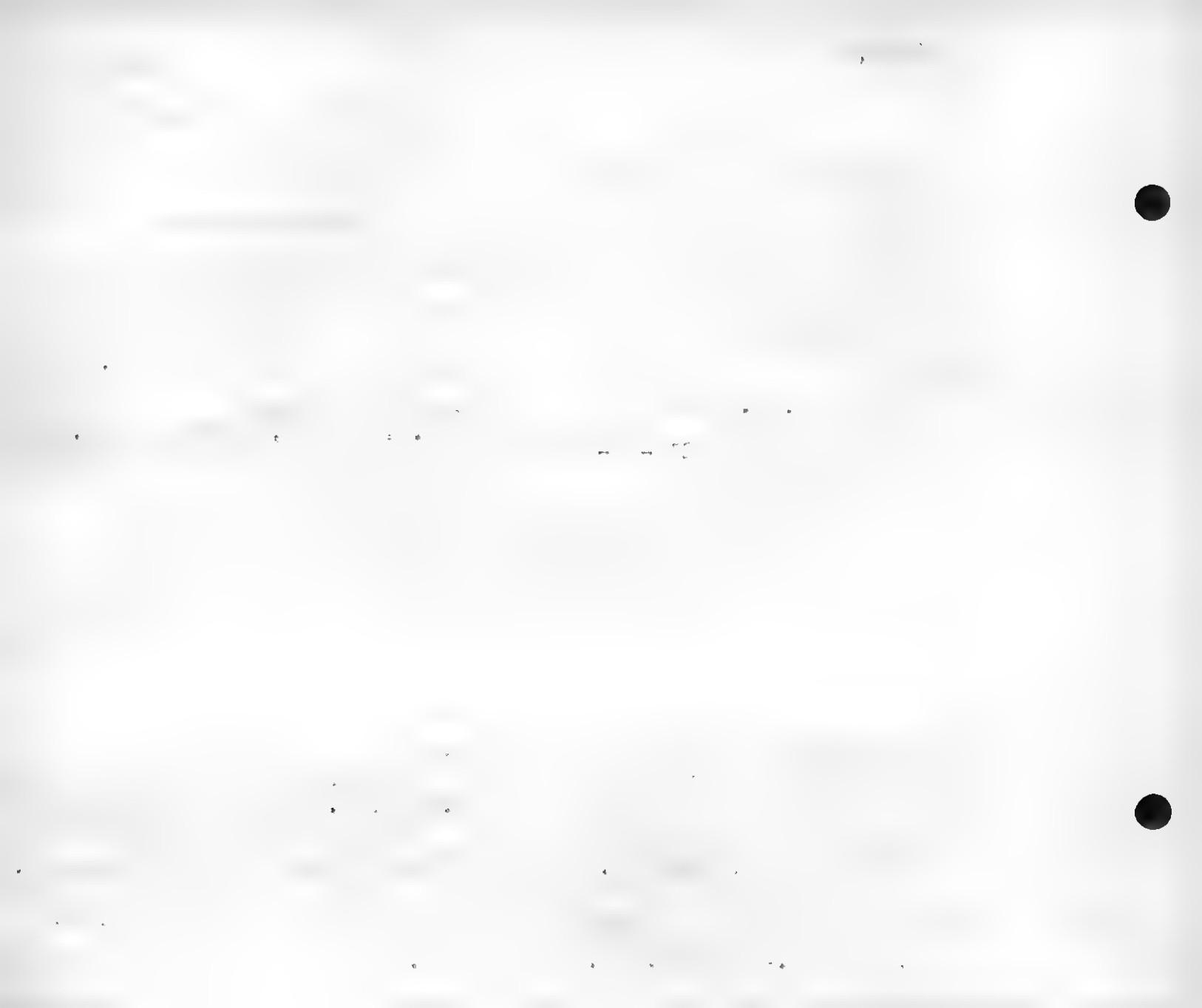
CERTIFICATE OF DEATH

14731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 1/9/1960	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 515 Memorial Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Bernard	Last Kelley
4. DATE OF DEATH November 11, 1967	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1911
9. AGE (In years at birthday) 55 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James M. E. Kelley	14. MOTHER'S MAIDEN NAME Amelia M. Beale	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-07-5457C		17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>Arterio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arterio</u> DUE TO <u>Arterio</u> last (c) <u>Arterio</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/9/1960</u> , 19, to <u>11/11/1967</u> , that (I) (we) last saw the deceased alive on <u>11/11/1967</u> , and that death occurred at <u>P. M.</u> from causes and on the date stated above. at <u>9:30 P. M.</u> M.D. ATTENDING <input checked="" type="checkbox"/> MED. PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22a. SIGNATURE <u>George M. Simons</u>	22b. DATE SIGNED <u>11/13/1967</u>		
22c. PHYSICIAN'S NAME (Type) George M. Simons, M.D.	22d. ADDRESS Memorial Hospital, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/14/67	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr., 220 Balto. Ave., Cumberland, Md.	25a. ADDRESS John J. Hafer, Jr., 220 Balto. Ave., Cumberland, Md.	25b. RECEIVED BY REGISTRAR NOV 15 1967	25d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

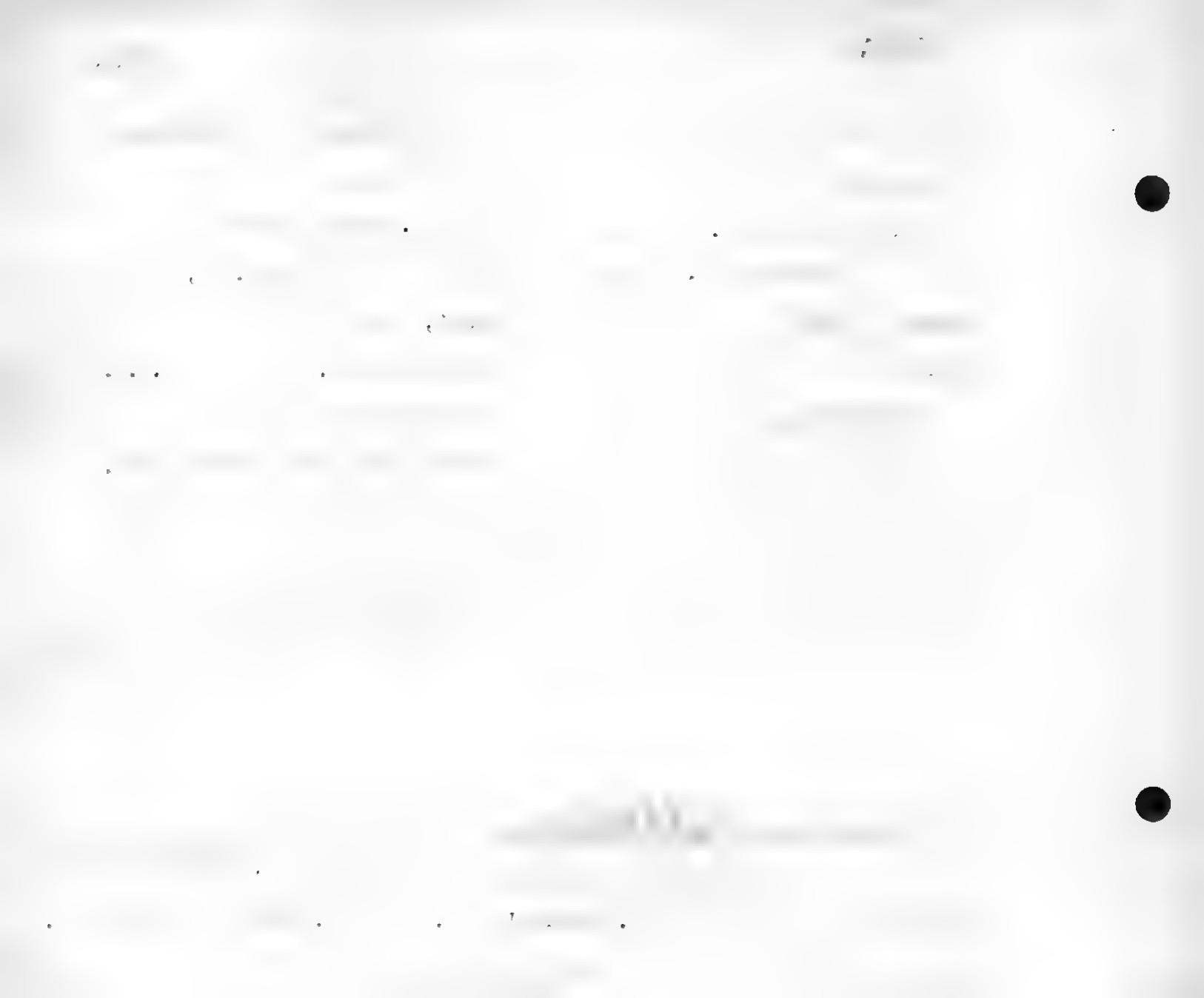
after death. If any delay is
- Give Pages 1, 2, and 3 to
along with form PM3. Page
with the State Department

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, on the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office and 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE		b. COUNTY			
Allegany				Maryland		Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Cumberland				Cumberland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS					
Sacred Heart Hosp.				208 N. Center Street					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4 DATE OF DEATH	Month	Doy	Year	
Margaret E. Kenny					Nov. 20,			1867	
S. SEX	6 COLOR OR RACE	7 MARRIED	NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH	9 AGE (in years lost birthday) yrs.	10 UNDER 1 YEAR	11 UNDER 24 HRS		
Female	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	June 2, 1884	83	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Nurse				Lonaconing Md.		U.S.A.			
13. FATHER'S NAME									
Edward Kenny				Mary Ann Conroy		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT					
No				Miss Sadie Kenny Cumberland Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Hydrothorax DUE TO Shock Anemia INTERVAL BETWEEN ONSET AND DEATH Days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Anemia DUE TO (c) Bleeding Peptic Ulcer 1									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Fracture of Left Fibula 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in Hallway of her home							
20c. TIME OF INJURY Month, Day, Year Hour pm		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) House		20f. (City or town) Cumberland, Alleg. Md.		(County) Calvert Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skarola M.D. 22. DATE SIGNED Nov. 22, 1967									
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 111 W. Main St., Suite 101, Cumberland, Alleg. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/67		23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cem.		23d. LOCATION (City or Town) Mt. Savage		(County) Allegany Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		ADDRESS		25a. RECD BY REGISTRAR NOV 22 1967		25b. REGISTRAR'S SIGNATURE John C. ...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Return page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #14722 11/29/67 ph

14733

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 610 MARYLAND AVENUE	
f. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CANDACE E. KERNS		4. DATE OF DEATH NOVEMBER 18 1967	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. FATHER'S NAME JOSEPH EATON		14. MOTHER'S MAIDEN NAME MARY BORHOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure, Rf + left		INTERVAL BETWEEN ONSET AND DEATH over week	
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis & Hypertension Heart Disease 10cm		(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Diabetic accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/18/67 , to 11/18/67 , that (I) (we) last saw the deceased alive on 11/18/67 , and that death occurred at 5:27 PM from causes and on the date stated above		22b. DATE SIGNED 11/18/67	
22a. SIGNATURE Weisman		22b. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
22c. PHYSICIAN'S NAME (Type) S.G. WEISMAN, M.D.		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany Co.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1967	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS Judge	
		25b. REGISTRAR'S SIGNATURE NOV 27 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

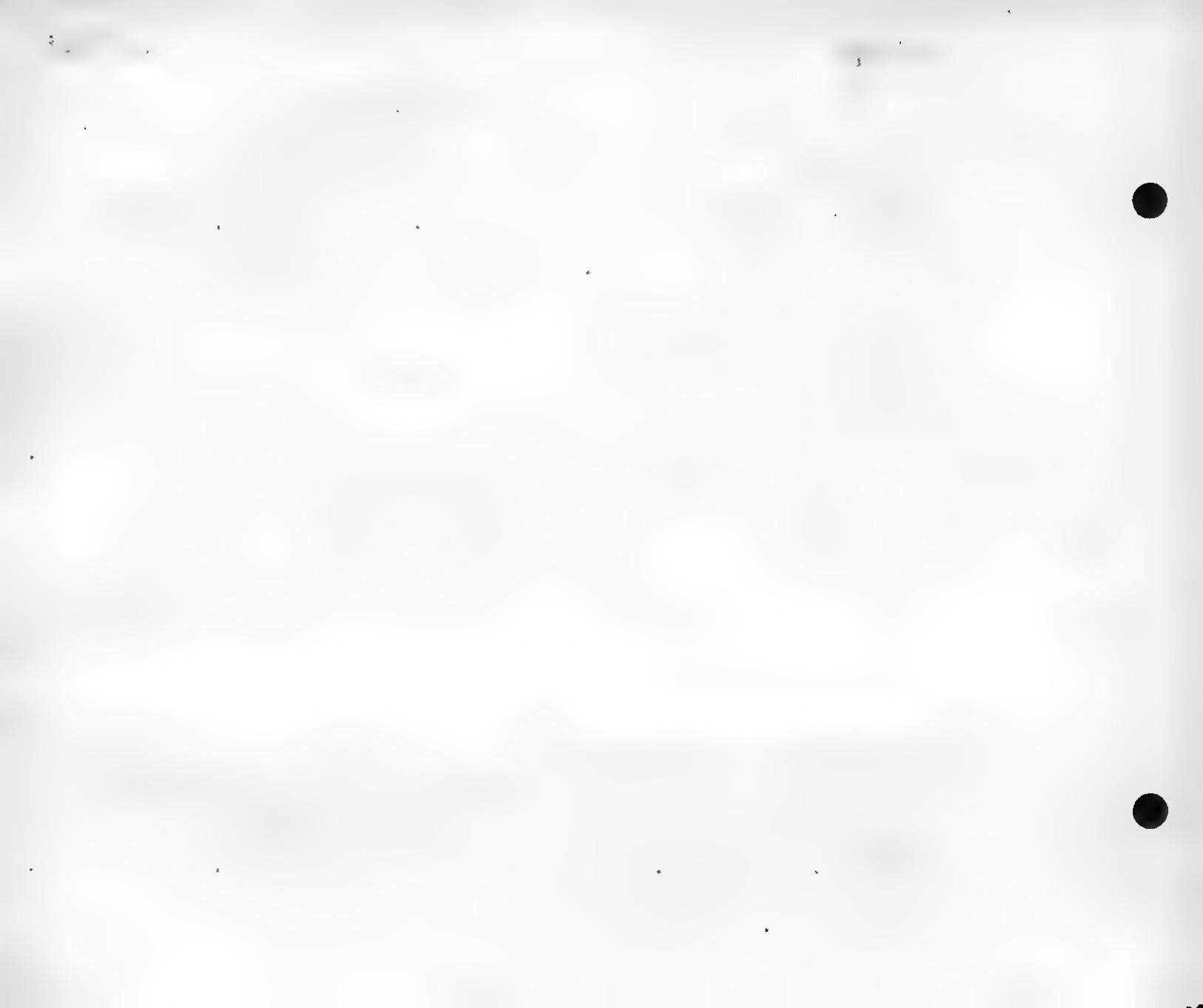
14723

14734

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1HR 825MI	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS LIVES IN CORRIGANVILLE RT. #1, HYNDMAN, PA. (MAIL ADDRESS)	
f. First MYRTLE		Middle F. LOCKARD	
g. Last SMITH, RICHARD		4. DATE OF DEATH Month NOVEMBER	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/12/94		9. AGE (in years last birthday) 72 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Hazen, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SMITH, RICHARD		14. MOTHER'S MAIDEN NAME ELLA (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic congestive heart failure, Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) While at work	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 AM , 19 67 to 11-3 1967 , that (I) (we) last saw the deceased alive on 11-2 1967 , and that death occurred at 11-3 1967 , from causes and on the date stated above.		22b. DATE SIGNED 11/7/67	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 5, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Ma	
24. FUNERAL DIRECTOR William G. Kight		25a. REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE J. K. Kight, Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14735

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death, if any delay is necessary. Please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14724		2							
1. PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)							
a. COUNTY Allegany		STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		b. COUNTY Allegany							
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If out of corporate limits, write RJRAL and give nearest town) Lonaconing							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Detmold Street		d. STREET ADDRESS Detmold Street							
e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3 NAME OF DECEASED (Type or print) JOHN		First JOHN	Middle MAC	Last NAMARA	4. DATE OF DEATH 11/21/1967	Month 19	Day Year		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/22.1897	9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HAIR Hairs 0	13. CIT ZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret'd) Retirec Postal Clerck Railroad		10b. KIND OF BUSINESS OR INDUSTRY Ireland		11. BIRTHPLACE (State or foreign country) Ireland		12. ADDRESS Rella Mac Namara, Lonaconing, Md. (WIFE)			
13. FATHER'S NAME Daniel Mac Namara		14. MOTHER'S MAIDEN NAME Minnie Conroy							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 041-1892698		17. INFORMANT Rella Mac Namara, Lonaconing, Md. (WIFE)		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, whch gave rise to immediate cause (a), stating the underlying cause last. Coronary Occlusion		DUE TO (b) Coronary Sclerosis		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDT ON GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>									
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.									
23a. BURIAL/CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/1967		23c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.			
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.				25a. REC'D BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT



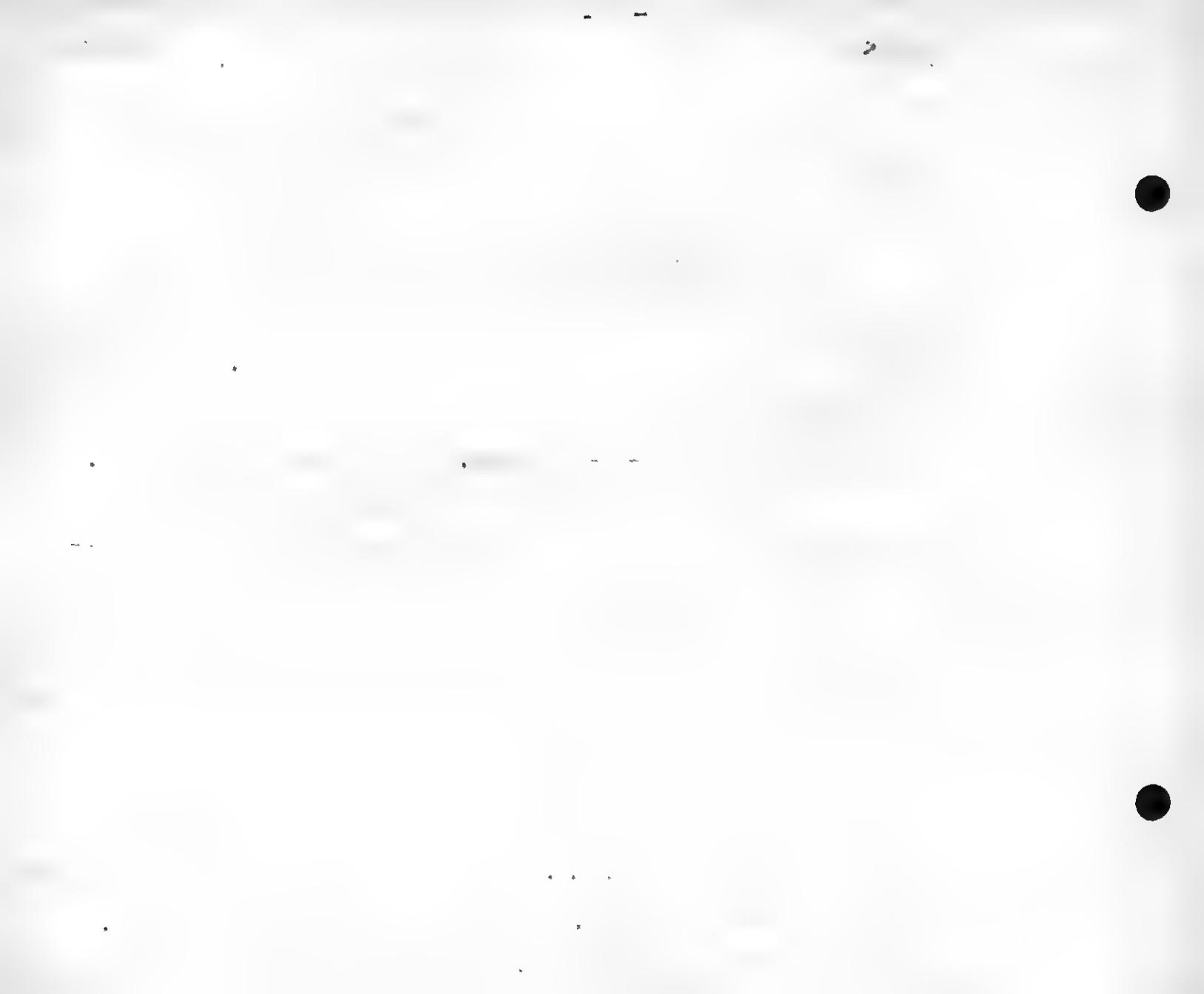
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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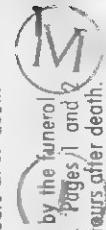
14725

14736

1 PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				
		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				
		f. STREET ADDRESS				
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) James De Sales Maher		First James	Middle De Sales			
4 DATE OF DEATH 11/27/1967		Month 11	Day 27			
5 SEX Male		6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1/23/1895		9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Vale Summitt, Md.			
13. FATHER'S NAME William Maher		12. CITIZEN OF WHAT COUNTRY? USA				
14. MOTHER'S MAIDEN NAME Mary Haththorne		15. ADDRESS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) If yes give war or dates of service Yes - World War #1		16. SOCIAL SECURITY NO. 219-36-9357	17. INFORMANT Mrs. Mary Maher, Midland, Md. (Wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden				
		Coronary Occlusion				
		Coronary Sclerosis				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				
20c. TIME OF INJURY Month, Day, Year Hour or p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Maryland				
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED 11/27/1967				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Michaels Cemetery Lonaconing, Md.	23d. LOCATION (City or Town) Frostburg, Md.	(County)	(State)
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR DEC 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR ATSMC (5) 6M 1/67						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14725

14737

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.	
3. NAME OF DECEASED (Type or print) First CAROLINE Middle FLORENCE Last MARTIN		4. DATE OF DEATH Month NOVEMBER Day 14 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) CUMB., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMBROSE RICKER		14. MOTHER'S MAIDEN NAME MARGARET J. CONNERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Hemorrhage) OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cerebral Hemorrhage stating the underlying cause (c) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13 1967</u> to <u>Nov 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 14 1967</u> , and that death occurred at <u>45P M</u> , from causes and on the date stated above.			
22a. SIGNATURE DR. G. O. HIMMELWRIGHT		22b. DATE SIGNED 11/16/67	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/67	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumb. Md.	25a. REC'D BY REGISTRAR NOV 20 1967
			25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

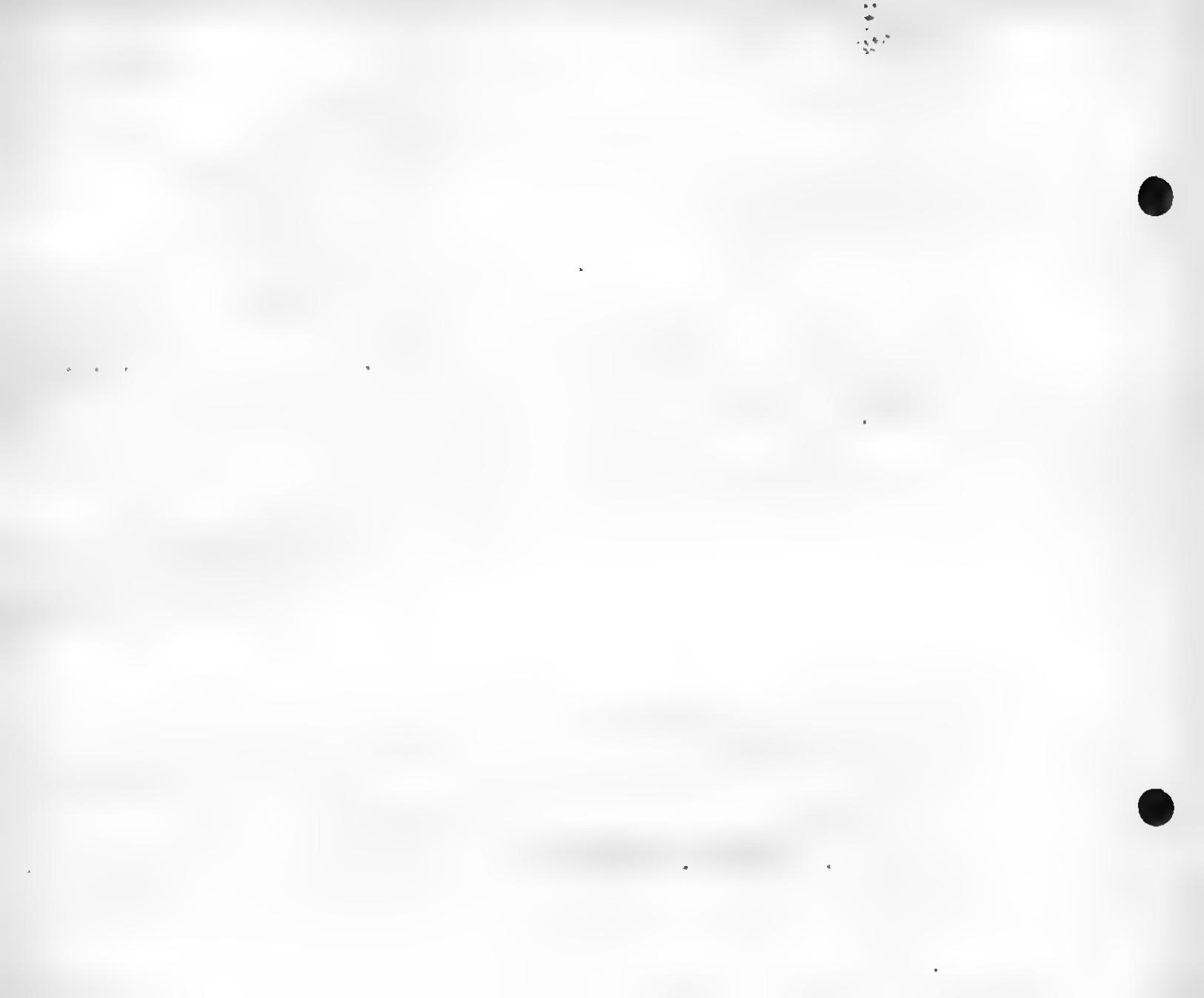
14727

CERTIFICATE OF DEATH

14738

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN lb 66 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
3 NAME OF DECEASED (Type or print)	First MAZA	Middle G.	Last MC COY
S SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1889
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID J. MILLER		14. MOTHER'S MAIDEN NAME XX CATHERINE ROBINETTE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>pt hemiplegia & aphasia</i> due to <i>Arterosclerosis central</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Jan 22</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterosclerosis central</i> due to <i>pt hemiplegia & aphasia</i> (c)		<i>Jan 22</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Memorial Hospital</i>
20f (City or town) <i>Cum</i>		(County) <i>Bedford</i> (State) <i>Penna.</i>	
21. I certify that (I) (this hospital) attended the deceased from 9-22-1967, 1967, that (I) (we) last saw the deceased alive on 11-27-1967, and that death occurred at 12:49 AM, from causes and on the date stated above.			
22a. SIGNATURE <i>J. Miller</i>		22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) DR. SAMUEL KIRKIN	
22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 29 NOV 67	23c. NAME OF CEMETERY OR CREMATORIAL CENTERVILLE CENT.
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		ADDRESS 25a. REC'D BY REGISTRAR DA NOV 30 1967	
		25b. REGISTRAR'S SIGNATURE <i>H. Lee Silcox</i>	

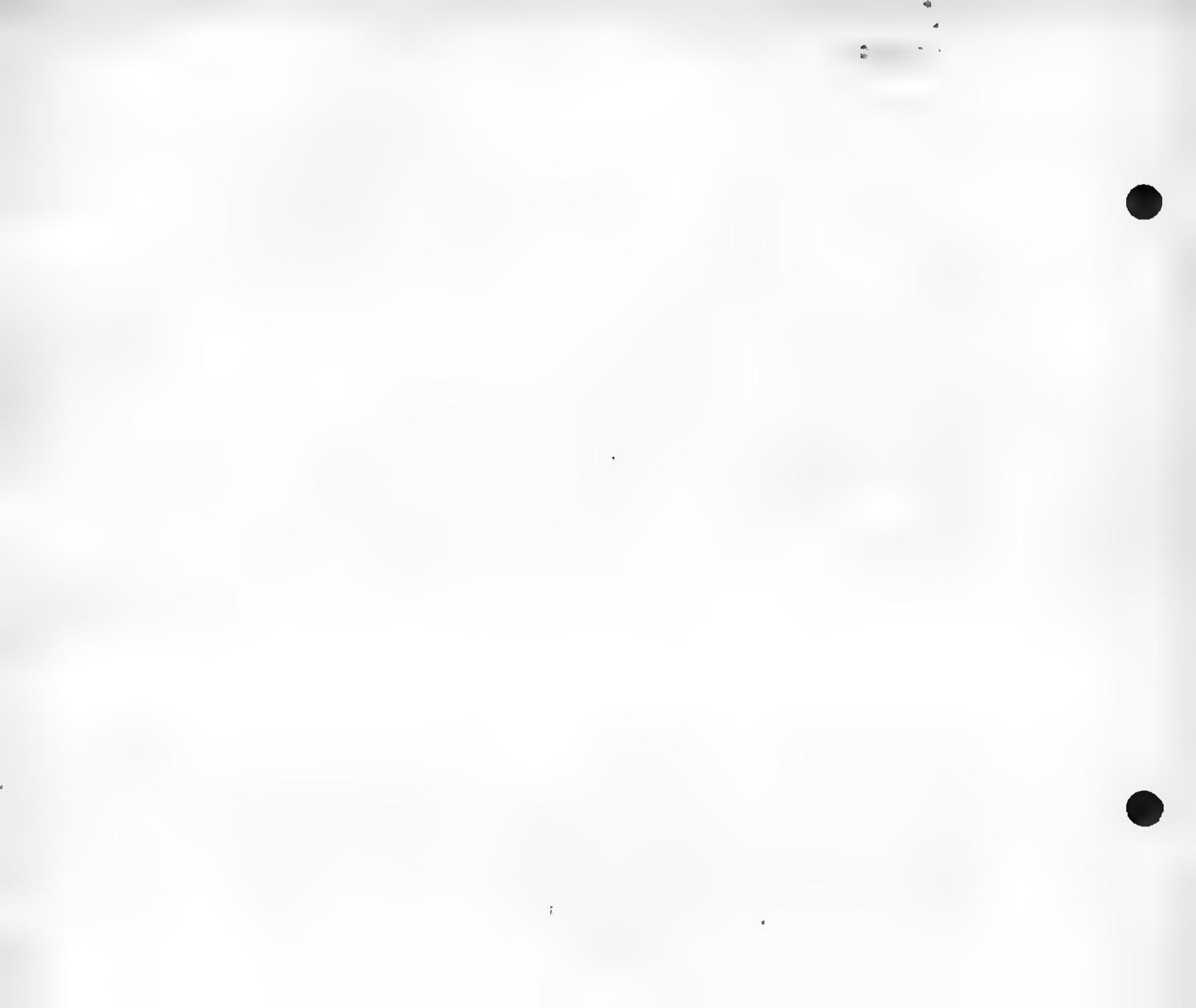


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 73 OLMOND STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PATRICK ROBERT MCKENZIE		First PATRICK	Middle ROBERT
		Last MCKENZIE	4. DATE OF DEATH Month NOVEMBER
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRUCK DRIVER		9. DATE OF BIRTH MAY 14, 1896	
10. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. AGE (In years last birthday) yrs. 71	
12. FATHER'S NAME PATRICK MCKENZIE		13. MOTHER'S MAIDEN NAME RACHEL HUTZELL	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW1		15. SOCIAL SECURITY NO 217-10-6121	
16. INFORMANT MRS. GERTRUDE MCKENZIE, FROSTBURG, MD.		17. INFORMANT Address MRS. GERTRUDE MCKENZIE, FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO 400 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema DUE TO years - (c) arteriosclerosis DUE TO years -			
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) FROSTBURG		(County) ALLEGANY (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 67 to 11/10 , 19 67 , that (I) (we) last saw the deceased alive on 11/10 , 19 67 , and that death occurred at 4PM , from causes and on the date stated above.			
22a. SIGNATURE <i>John B. Davis</i>		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 13 '67	23c. NAME OF CEMETERY OR CREMATORIAL ST. ANN'S CEMETERY
23d. LOCATION (City or Town) GARFIELD COUNTY		(County) ALLEGANY (State) MARYLAND	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD. 21532	25b. REG'D BY REGISTRAR DATE NOV 14 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. ^{Page 1 and 2} should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours of death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
ZEMA 1/43

CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			< LENGTH OF STAY IN lb 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART					d. STREET ADDRESS 106 DECATUR ST.			e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK		First	Middle	Last	4. DATE OF DEATH NOVEMBER		Month	Day	Year
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-97	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROADING			10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES Mc Millan					14. MOTHER'S MAIDEN NAME MERLE ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. 705-09-3519		17. INFORMANT HOSPITAL RECORD			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cong Pulmonale with Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-radiation Scarring, Rt. Lung</u> DUE TO (c) <u>Carcinoma, Rt. Lung</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-9</u> , 19 <u>67</u> , to <u>11-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-18</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Calvin Y. Hadidian</u>					MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) CALVIN HADIDIAN					22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.				
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park		23d. LOCATION (City or Town) Frostburg, Md. Allegany		(County) (State)	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME CUMBERLAND, MD.					25a. REC'D. BY REGISTRAR NOV 22 1967				
					25b. REGISTRAR'S SIGNATURE <u>Calvin Y. Hadidian</u>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14741

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 finds 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND	c. LENGTH OF STAY IN lb 13 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND	d. STREET ADDRESS 412 LOUISIANA AVENUE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELTA	First MARY	Middle MEAGHER	4. DATE OF DEATH Month NOVEMBER Day 24 Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 5/15/91		9. AGE (In years last birthday) 76 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (County & State, or foreign country) SHAFT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR X MEAGHER		14. MOTHER'S MAIDEN NAME TIPPEN, GEORGE MORGAN, MARGARET	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service NO N.A.		16. SOCIAL SECURITY NO 213-01-5956	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>loss of feet with melanoma</i> DUE TO <i>through ulcer</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>loss of feet with melanoma</i> DUE TO <i>through ulcer</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) <i>falling down</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nov 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, offce bldg, etc) Home
20f. (City or town) CUMBERLAND		(County) (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from July 1966 to Nov 24, 1967 that (I) (we) last saw the deceased alive on July 1966 , and that death occurred at 4:30 AM causes and on the date stated above.			
22a. SIGNATURE <i>B. Schindler</i>		22b. DATE SIGNED 11/26/67	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/27/67	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY FROSTBURG
23d. LOCATION (City or Town) MARYLAND		(County) (State)	
24. FUNERAL DIRECTOR CHARLES J. SOWERS HAFFER-SOLOMONS FUNERAL HOME		25a. ADDRESS 60 W. MAIN FROSTBURG	25b. REG'D BY REGISTRAR NOV 29 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Sowers</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						16250								
PLACE OF DEATH a. COUNTY Allegany			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN lb 2/9/1967			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary			d. STREET ADDRESS Route #1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Anna Elizabeth Mellott		First	Middle	Last	4. DATE OF DEATH Month November Day 29, Year 1967	Month	Day	Year	5. IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1894	9. AGE (in years last birthday) 73 yrs			10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Somerset County, Pa.			12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Herman Hosselrode			14. MOTHER'S MAIDEN NAME Jennie Fechner						21502					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebrovascular accident INTERVAL BETWEEN ONSET AND DEATH 5 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerosis. years lost DUE TO (c) Chronic hypertension l.v.d. years														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus obesity, Egog. Left hemiplegia 12/66														
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY Month, Day, Year Hour o.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Feb. 9, 1967			20f. (City or town) (County) (State) P. M.		
21. I certify that (I) (this hospital) attended the deceased from Nov. 29, 1967 , to Nov. 29, 1967 at (I) (we) last saw the deceased alive on Nov. 29, 1967 , and that death occurred at P. M. from causes and on the date stated above.			22a. SIGNATURE John A. Toppes			at 11:10 P. M. ATTENDING MD <input checked="" type="checkbox"/> PHYS <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> PHYS <input type="checkbox"/>			22b. DATE SIGNED Dec 1-1967					
22c. PHYSICIAN'S NAME (Type) John A. Toppes			22d. ADDRESS Memorial Hospital, Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 2, 1967			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Palo Alto Cemetery			23d. LOCATION (City or Town) (County) (State) Hyndman, Pa. Bedford Co.					
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.						25a. REGD. BY REGISTRAR DEC 7 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

If any delay is
necessary, please execute the certificate, writing the word "Pending" in pen in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
PM3. Page 5 may be retained for your files.

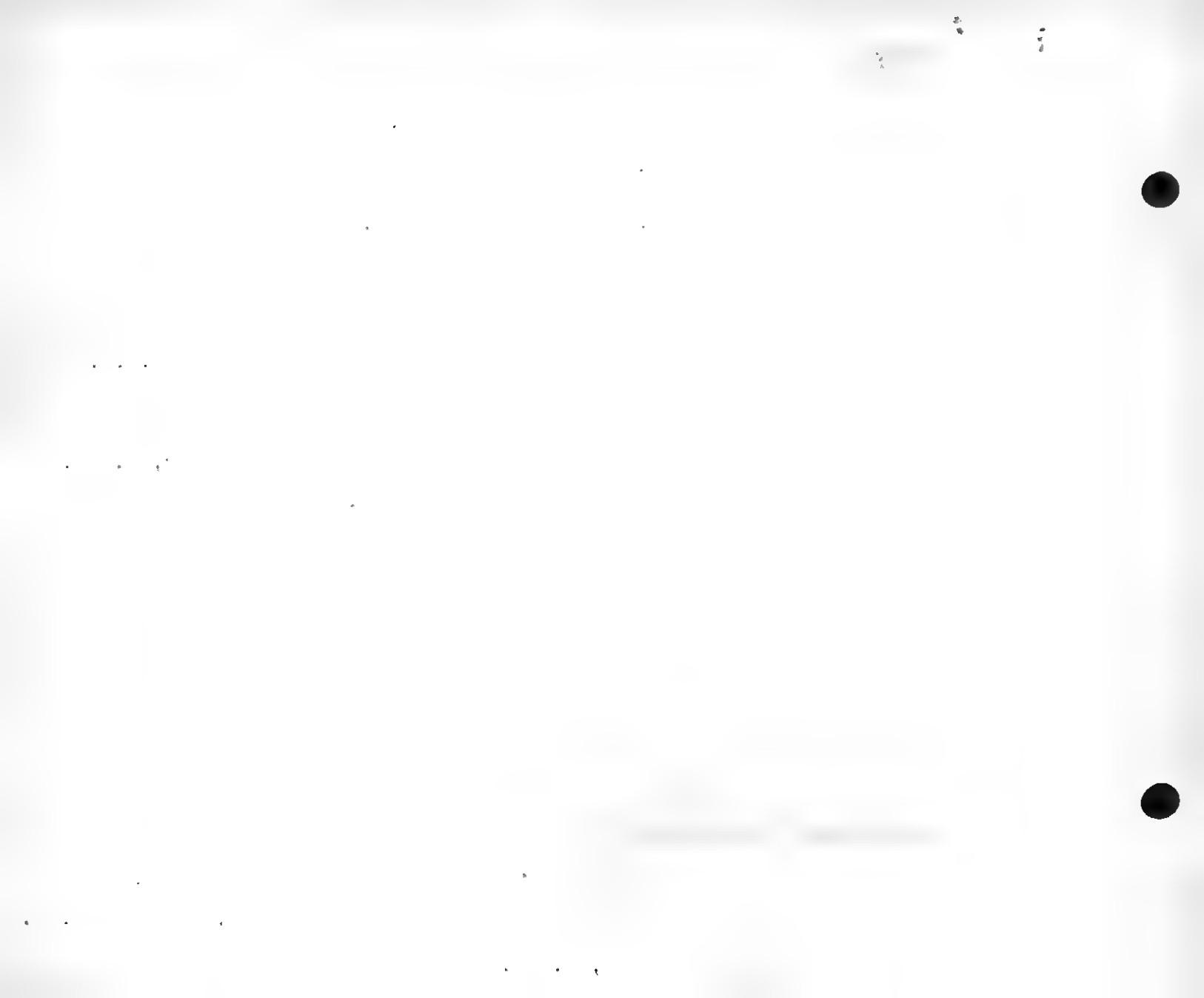
File pages 1 and 2 with the State Department of
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

14738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14742

1 PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE W.Va.		b. COUNTY Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN lb -----		c CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Keyser		d. STREET ADDRESS Rt. # 2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital---DOA				e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3 NAME OF DECEASED (Type or print) Walter C Metcalf		First	Middle	Lost	4 DATE OF DEATH November 7 Dec 1911	Month	Day	Year
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7 Dec 1911	9 AGE (In years last birthday) 55 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector RR		10b KIND OF BUSINESS OR INDUSTRY Railroad		11 BIRTHPLACE (State or foreign country) West Virginia		2 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Metcalf		14. MOTHER'S MAIDEN NAME Margaret Ellifritz						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes WW 11		16 SOC. SECURITY NO		17 INFORMANT Margaret metcalf		Address RD 2 Keyser, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4101		Coronary Thrombosis, Right		INTERVAL BETWEEN ONSET AND DEATH Sudden				
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause ost		DUE TO (b)	Coronary Intimal Hemorrhage		--			
		DUE TO (c)	Coronary Sclerosis, Marked		----			
PART I OTHER CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)						
20c TIME OF INJURY Month, Day Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town)	(County)	(State)		
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Benedict Skitarelic		
ACTUAL SIGNATURE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 4, 1967		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7 Nov 1967	23c NAME OF CEMETERY OR CREMATORIUM Thrush	23d LOCATION (City or Town) Antioch, Mineral W. Va.		(County) (State)		
24. FUNERAL DIRECTOR Allen M. Rotnick		ADDRESS Keyser, W. Va.	25a REC'D BY REG STAR Nov 7 1967		25b REGISTRAR'S SIGNATURE Charles Judge		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14733

CERTIFICATE OF DEATH

14743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 74 FROST AVENUE	
e. NAME OF DECEASED (Type or print) JOHN		First B	Middle
f. LAST METZGER		Last 	4 DATE OF DEATH NOVEMBER 1 1967
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH 9-19-84		9. AGE (In years less birthday) 83 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN S. METZGER		14. MOTHER'S MAIDEN NAME FLORENCE KELLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 214-05-4821	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 43 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 6 days	
IMMEDIATE CAUSE (a) 43 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Chronic latent cardiac decompensation A. S. cardiovascular disease	
DUE TO Chronic latent cardiac decompensation A. S. cardiovascular disease		3 months 17 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recurrent Papilla Carcinoma Bladder, 5 years Chronic Heart?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>(Refused)</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 m. , 19 50 , to 1 nov. , 19 67 , that (I) (we) last saw the deceased alive on 1 nov. 19 67 , and that death occurred at 8:45 p.m. from causes and on the date stated above		22b. DATE SIGNED 7 nov. 67	
22c. SIGNATURE W. Alfred van Ormer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 7 nov. 67
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 4 '67	
23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		ADDRESS 25a. REC'D BY REGISTRAR DATE NOV 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14734

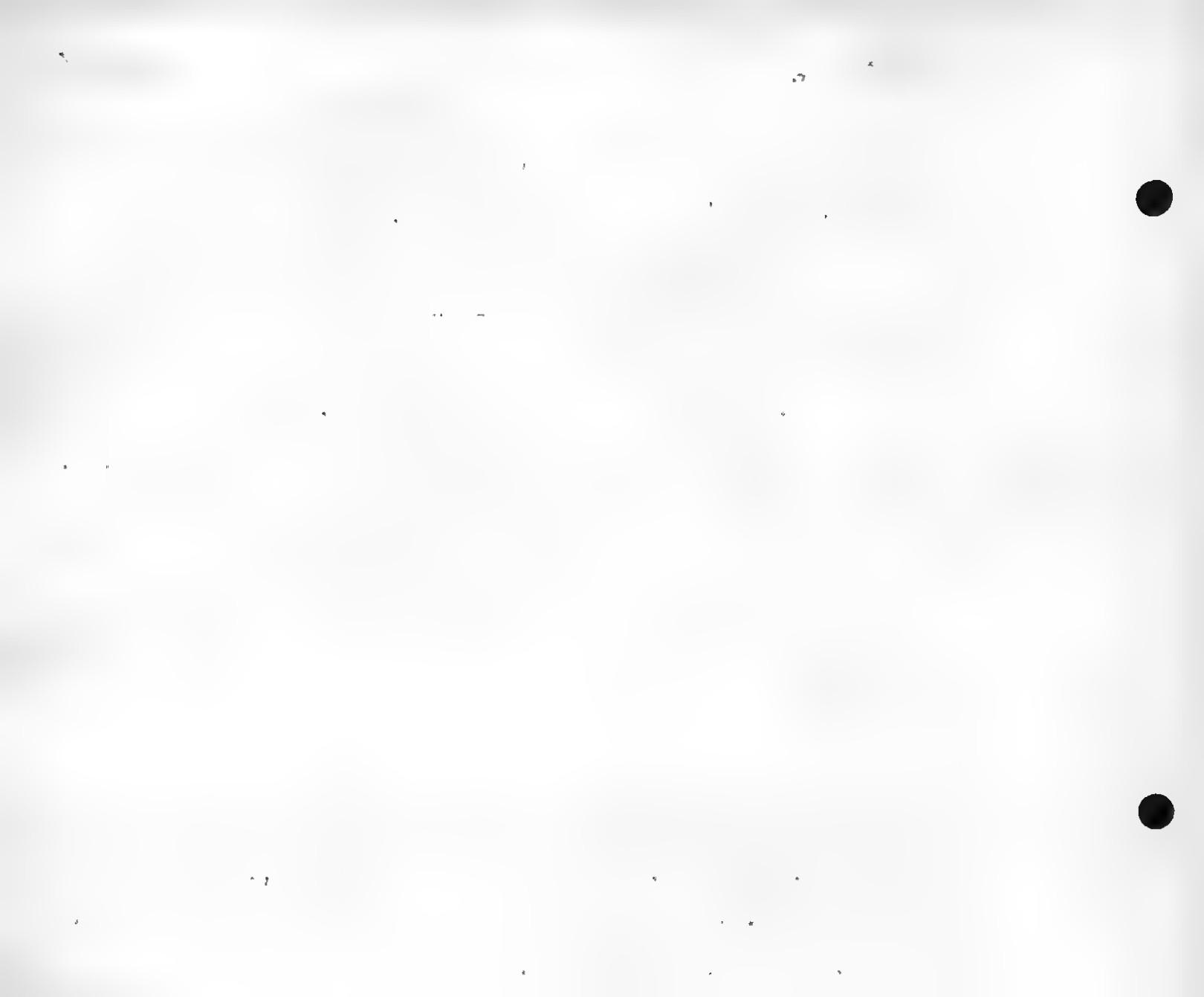
CERTIFICATE OF DEATH

14744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 from this certificate and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 6HRS 10MIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS P.O. BOX 48 CHURCH ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DONALD	Middle ARTHUR	Last MILLER
4. DATE OF DEATH	Month NOVEMBER	Day 5	Year 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-28-1967	9. AGE (in years last birthday) yrs 8	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS Days 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND	
13. FATHER'S NAME DAVID A. MILLER	14. MOTHER'S MAIDEN NAME BARBARA J. BOHN	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) pneumonia			
DUE TO 2890			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) Hurler's Syndrome			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH 8 mo.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 6:50 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Robert J. Dawson</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT J. DAWSON		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, BURTAD BURTAD		23b. DATE THEREOF NOV. 8, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Lybarger Cemetery		23d. LOCATION (City or Town) (County) (State) Buffalo Mills, Pa. RD#1	
24. FUNERAL DIRECTOR HARVEY H. ZEIGLER, HYNDMAN, PA.		25a. RECEIVED BY REGISTRAR DATE NOV 13 1967	
		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transport permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if inst tut or Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
f. STREET ADDRESS 217 W. MAIN STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LULU		First LULU	Middle MINNICK
4. DATE OF DEATH NOVEMBER 1, 1967	Month NOVEMBER	Day 1, 19	Year 67
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH FEB. 19, 1900	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most at working, i.e., even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME PETER CATON		14. MOTHER'S MAIDEN NAME CLARA MCKENZIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO NONE	17. INFORMANT Address MRS. ETHEL MCKENZIE, RT. 2, FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		ACUTE POSTERIOR Myocardial Infarction	
(b) DUE TO		ARTERIOSCLEROTIC HEART DISEASE	
(c)		7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 27 , 1967, to Nov 1, 1967 that (I) (we) last saw the deceased alive on Oct. 31 , 1967 and that death occurred at 10:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED Nov. 1, 1967	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M.D.		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 3, 1967	23c. NAME OF CEMETERY OR CREMATORIAL McKENZIE CEMETERY
23d. LOCATION (City or Town) GARRETT COUNTY, MD.		(County) (State)	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS 21532	25a. REC'D BY REGISTRAR NOV 6 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14736

CERTIFICATE OF DEATH

14746

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN b. LIFETIME	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 91 WRIGHT STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MATILDA	Middle ELIZABETH	Last MONAHAN
4. DATE OF DEATH	Month NOVEMBER	Year 25 1967	Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MARCH 30, 1889		9. AGE (In years last birthday) 78 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSHUA SPERRY		14. MOTHER'S MAIDEN NAME DORA ALTMILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. N.A.	
17. INFORMANT MRS. CARL CLARK, 91 WRIGHT STREET		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>recurrent 3 times</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>AHCVR disease</i> - (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from act - , 1967 to nov 25 1967 that (I) (we) last saw the deceased alive on nov 25 1967 , and that death occurred at 1A M, from causes and on the date stated above			
22a. SIGNATURE <i>John B. Davis, M.D.</i>		22b. DATE SIGNED 11/26/67-	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. MICHAEL'S CEM.
24. FUNERAL DIRECTOR MATILDA M. SOWERS, HAFFER-SOWERS FUNERAL HOME		23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND	
24a. ADDRESS 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR NOV 29 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Magee</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14737

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and attach to the burial permit. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

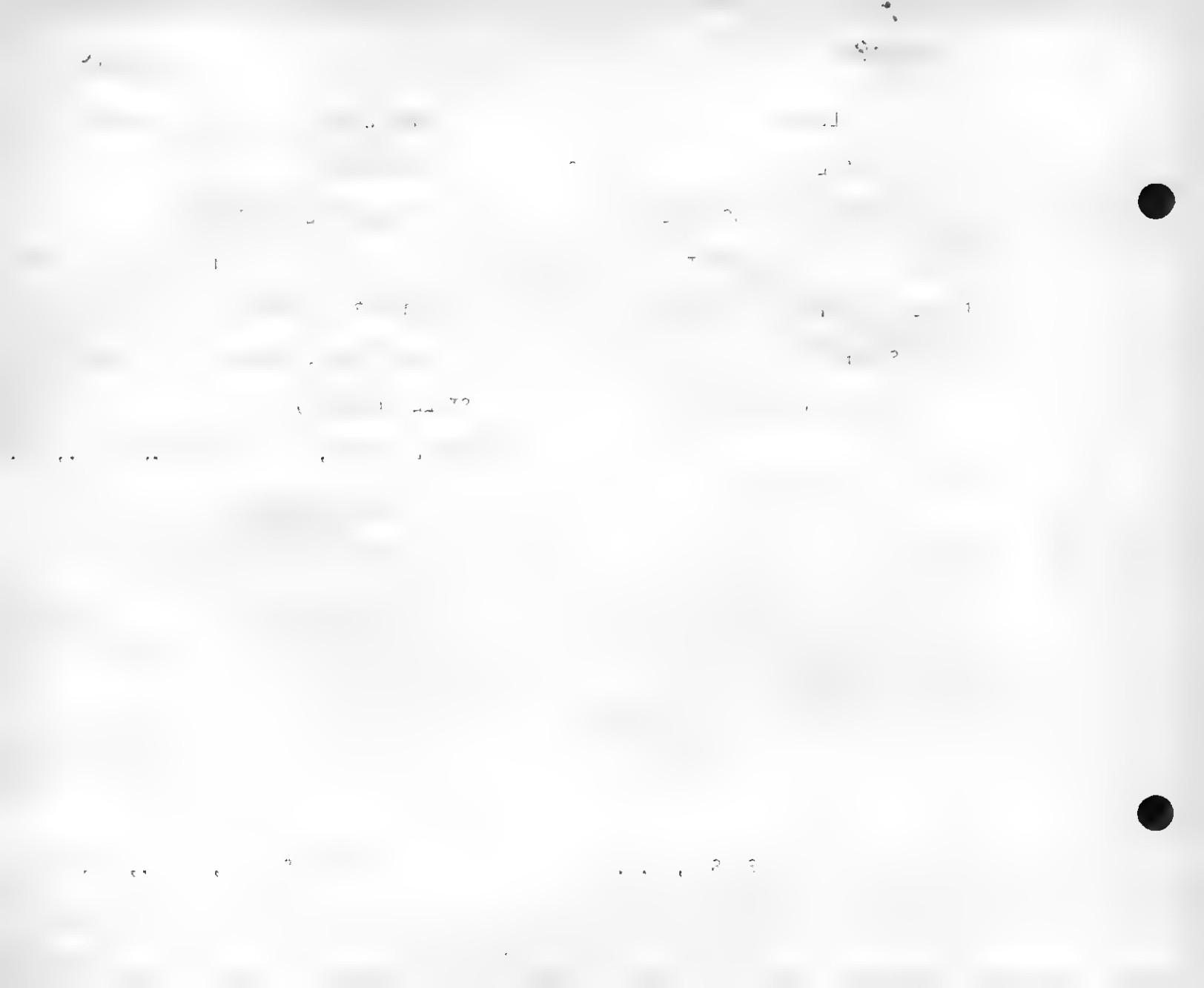
1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) b. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 305 ARCH ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) FEMALE	First NELLIE	Middle W.	Last MORRISON
4. DATE OF DEATH NOVEMBER 23 ¹⁹ 67	Month	Day	Year
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-5-1896	9. AGE (In years at birth) 71 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Rowlesburg	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LEWIS BUCKHOLDER	14. MOTHER'S MAIDEN NAME ZUELLA DEWITT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 218-38-0344	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH 24 hr	DUE TO (b) <i>Arteriosclerotic Cds</i> 5 days	DUE TO (c)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY, Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Cumberland</i> (County) <i>Alleghany</i> (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 16, 1967</i> , 19 <i>5:30 P.M.</i> , 19 <i>that (I) (we) last saw the deceased alive on <i>Nov. 23, 1967</i>, and that death occurred at <i>M.</i> from causes and on the date stated above</i>			
22a. SIGNATURE <i>R. J. Williams</i>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>Nov. 26, 1967</i>
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS	22d. ADDRESS CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 26, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Cumberland, Md. (County) Allegany (State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR No. 28 1967	25b. REGISTRAR'S SIGNATURE <i>J. F. Scarpelli</i>
VR A15 (4) 25M 1/67			



1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #7 & 9 information taken from birth cert.											
Item #13 Film #G274 11-2 1967											
1 PLACE OF DEATH						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)					
a. COUNTY ALLEGANY			MARYLAND			a. STATE MARYLAND			b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c LENGTH OF STAY IN lb 8 DAYS			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						d. STREET ADDRESS 316 CUMBERLAND STREET					
3 NAME OF DECEASED (Type or print)		First MARGARET	Middle Z	Last NAVE	4 DATE OF DEATH Month 11 Day 02 Year 1967					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX FEMALE		6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1903		9 AGE (in years at time of death) 64 yrs	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most working hours if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND			12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME ALFRED ZALMAN Zihlman						14. MOTHER'S MAIDEN NAME STELLA (DURST)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO			16. SOCIAL SECURITY NO			17. INFORMANT HOSPITAL RECORD, 200 SETON DR., CUMB., M.D.			Address		
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident (cerebral embolus) INTERVAL BETWEEN ONSET AND DEATH 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic duodenal ulcer with obstruction - status post -operative with vagotomy + gastrojejunostomy 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (This hospital) attended the deceased from 10-25 , 19 67 , to 11-2 , 19 67 , that (I) (we) last saw the deceased alive on 11-2 19 67 , and that death occurred at 10:15PM , from causes and on the date stated above.											
22a. SIGNATURE Andrew Stasko			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED 11-2-67					
22c. PHYSICIAN'S NAME (Type) ANDREW STASKO, M.D.			22d. ADDRESS 401 DECASTER STREET, CUMB., M.D. 21502								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/5/67			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Ph			23d. LOCATION (City or Town) (County) (State) Cumberland MD		
24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland MD			25a. RECD BY REGISTRAR DATE NOV 6 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14739

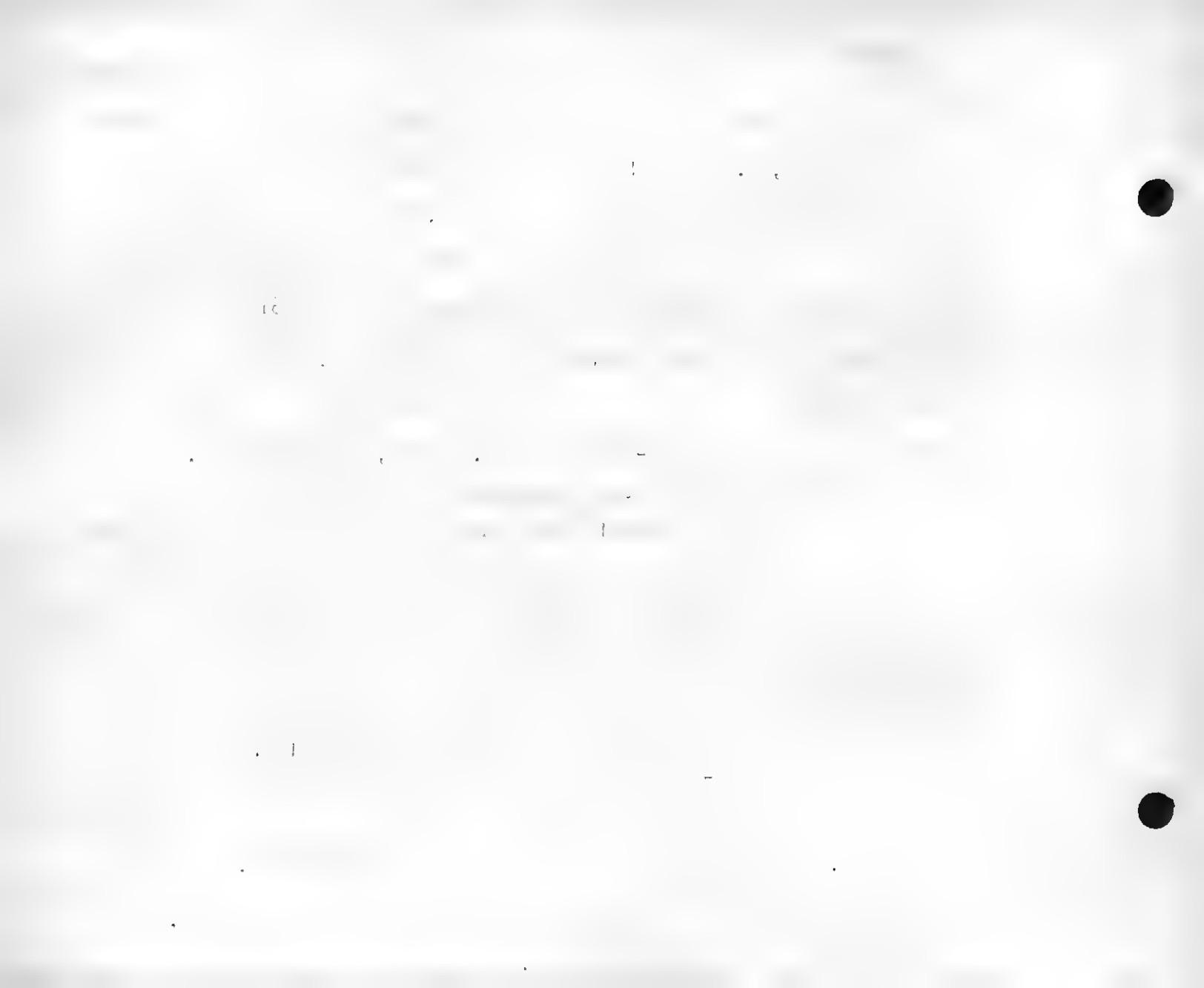
CERTIFICATE OF DEATH

14749

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper pages 1 and 2. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 1 DAY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS 83 W. COLLEGE AVE				f. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DANIEL		First	Middle	Last	4. DATE OF DEATH NOVEMBER 17 1967	Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-06	9. AGE (In years 18 months days years birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTAL CLERK		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY FROSTBURG, MD. COUNTY		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MICHAEL NOLAN		14. MOTHER'S MAIDEN NAME ELLEN (DURKIN)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-44-2035		17. INFORMANT 900 SETON DRIVE HOSP. RECORD, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		CONGESTIVE HEART FAILURE				INTERVAL BETWEEN 6 WEEKS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO RHEUMATIC HEART DISEASE				40 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11-16 67		20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-16 1967, to 11-17 1967, that (I) (we) last saw the deceased alive on 11-16 1967, and that death occurred at 4 A.M. from causes and on the date stated above.									
22a. SIGNATURE <i>Ralph B. Ballin</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-17-67					
22c. PHYSICIAN'S NAME (Type) DR. RALPH BALLIN		22d. ADDRESS 62 GREENE ST.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-20-67		23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) FROSTBURG, MD.		(County) (State)	
24. FUNERAL DIRECTOR DURST FUNERAL HOME		57 FROSTBURG AVE FROSTBURG, MD.		25a. REC'D BY REGISTRAR NOV 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judd</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

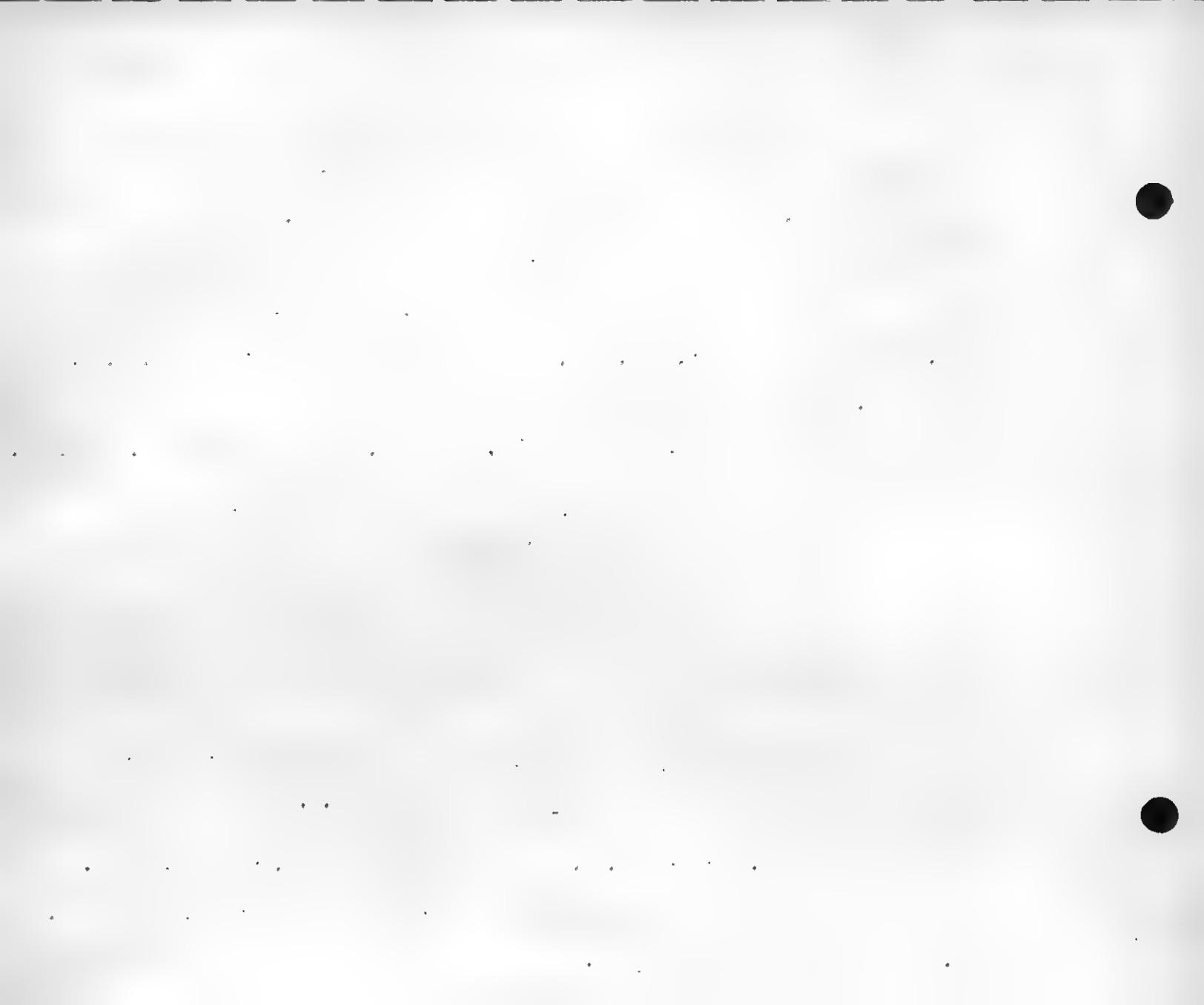
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper, pages 1 and 2, director, page 3, should be detached for use as the burial-transit permit. Then please reinsert carbon paper, pages 1 and 2, director, page 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14750

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Allegany MARYLAND		Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
306 Laing Ave.,		306 Laing Ave.,	
3. NAME OF DECEASED (Type or print)	First Harry	Middle Stansbury	Last Oss
4. DATE OF DEATH	Month November	Day 30	Year 1967
5. SEX	6. COLOR DR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVDRGED <input type="checkbox"/>	March 27, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	
Ret. carman	B. & O. Ry.	Cresaptown, Maryland	
12. CITIZEN OF WHAT COUNTRY?	U. S. A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
George W. Oss	Hattie Winters		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <input type="checkbox"/> (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No,	705-05-8525	Mrs. Cleona A. Oss	306 Laing Ave. Cumb. Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>Anemia</i>	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH ? 2 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1, 1967</i> , to <i>Nov. 30, 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov. 30, 1967</i> , and that death occurred at <i>12:15 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Clay E. Durrett</i>		A.M. 22b. DATE SIGNED <i>12/1/67</i>	
22c. PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.		22d. ADDRESS 236 Virginia Ave. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/67	
23c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR DATE DEC 4 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



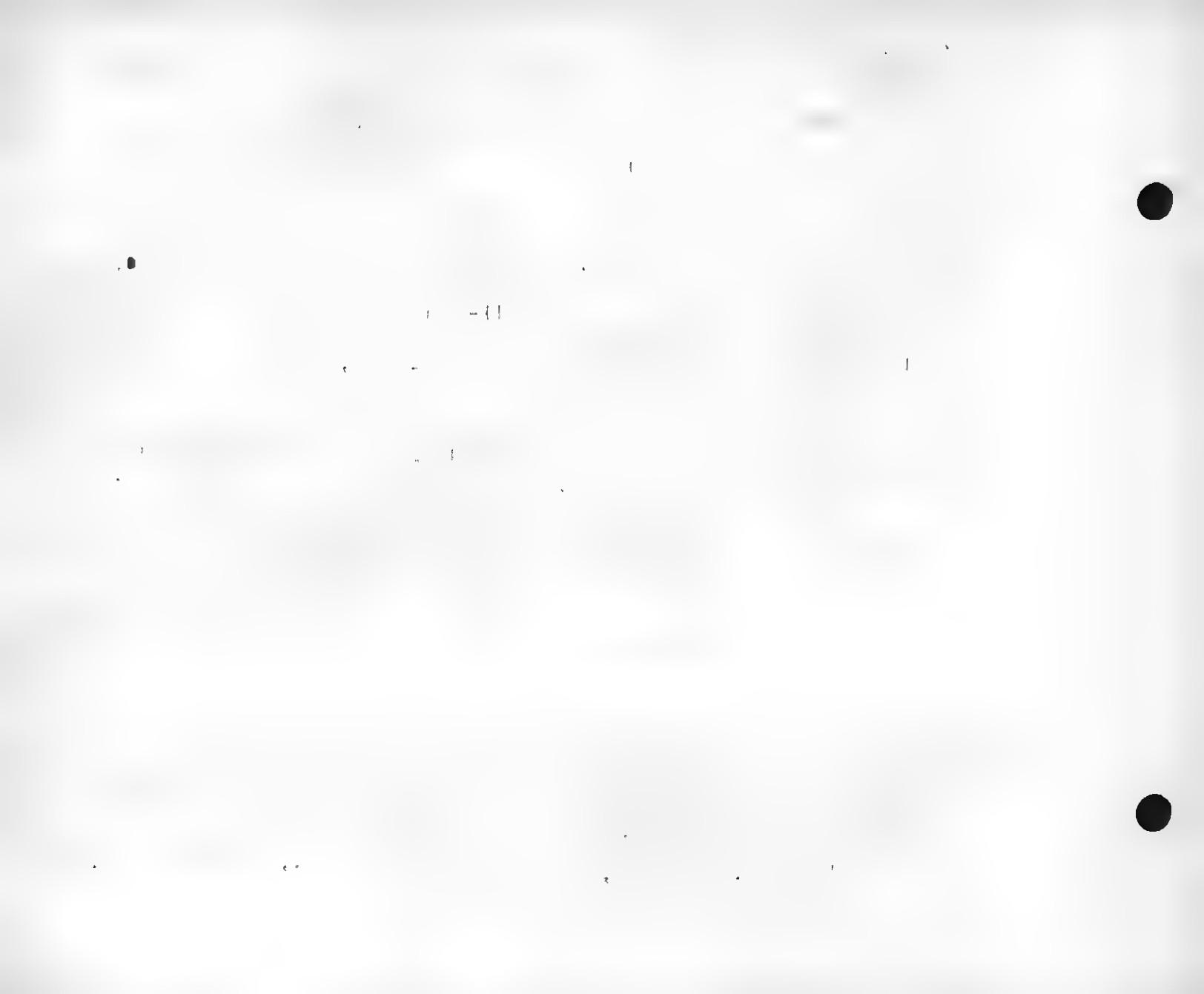
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						16258			
1 PLACE OF DEATH a. COUNTY ALLEGANY			2 USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE MARYLAND			25M			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 10 HRS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b COUNTY ALLEGANY			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			d STREET ADDRESS 7 WESTVIEW TERRACE			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First (FRED)	Middle FREDERICK S.	Last PALMER	4 DATE OF DEATH NOVEMBER 30, 1967	Month NOVEMBER	Day 30	Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-10	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	HOURS Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SILK WORKER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE		11. BIRTHPLACE (Country & State, or foreign country) ALLEGANY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES PALMER			14. MOTHER'S MAIDEN NAME ANNA DECKER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL CHART		Address SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Massive Peritonitis</i> , DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal Obstruction of Colon</i> , DUE TO (c) <i>Diverticulitis with Abscess Formation</i>						INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Septic - Endotoxic Shock</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERRUNG OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-29-1967 to 11-30-1967 , that (I) (we) last saw the deceased alive on 11-30-1967 , and that death occurred at M , from causes and on the date stated above.									
22a. SIGNATURE <i>Richard E. Schindler</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) RICHARD E. SCHINDLER, MD			22d. ADDRESS 69 GREENE ST., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 4, 1967		23c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 7 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14742

CERTIFICATE OF DEATH

14751

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN b 11 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 85 EAST MAIN STREET	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PASQUALE P. PARISE		First	Middle
4. DATE OF DEATH NOVEMBER 28, 1967		Last	Month Day Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 29, 1920		9. AGE (In years last birthday) 47 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) PARTNER		10b. KIND OF BUSINESS OR INDUSTRY STORE LIQUOR & CUT-RATE	11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH PARISE		14. MOTHER'S MAIDEN NAME CONCATTA CRIVARO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO N.A.		16. SOCIAL SECURITY NO 215-16-4729	17. INFORMANT Address MISS MARY PARISE, 85 E. MAIN ST., FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause cerebral ischemia. 10 days			
(b) DUE TO Generalized atherosclerosis. 10 years			
(c) DUE TO Diabetes mellitus. 12 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Jejunum, post operative		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nov. 17, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Nov. 17, 1967 , to Nov. 28, 1967 , that (I) (the) last saw the deceased alive on Nov. 28, 1967 , and that death occurred at 1:24 AM , from causes and on the date stated above.		22b. DATE SIGNED Nov 29, 1967	
22a. SIGNATURE Alvin J. Walters		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 48 BROADWAY, FROSTBURG, MARYLAND
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/30/67	23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CEMETERY
23d. LOCATION (City or Town) FROSTBURG, MARYLAND		(County) (State)	
24. FUNERAL DIRECTOR ARTIOL M. SCOTT'S HAIFER-SCHLERS FUNERAL HOME		25a. ADDRESS 60 W. MAIN, FROSTBURG	25b. REC'D BY REGISTRAR DEC 4 1967
		25b. REGISTRAR'S SIGNATURE J Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14743

CERTIFICATE OF DEATH

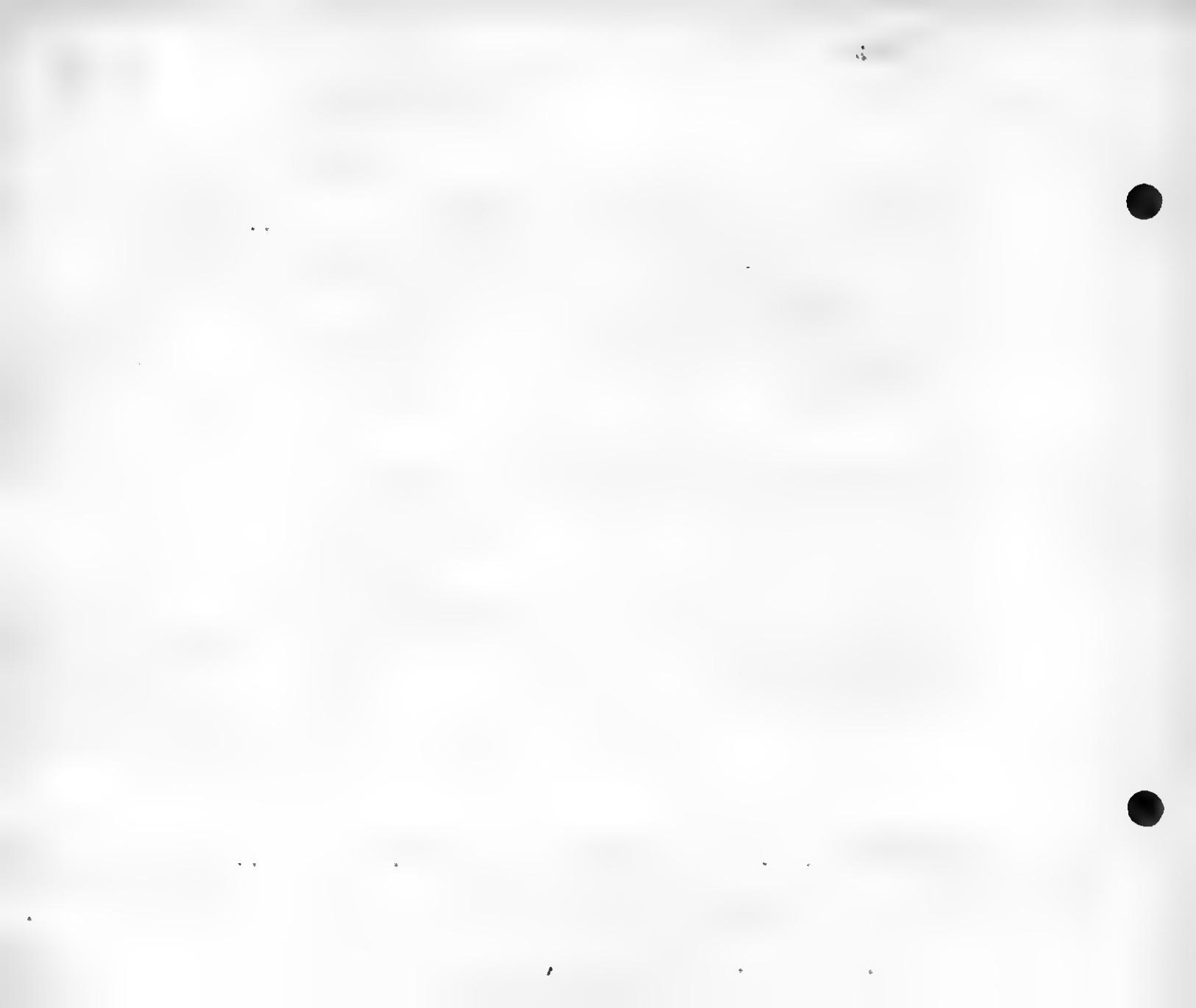
14752

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND 31 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 363 BEDFORD ST., CUMBERLAND	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED First ALTHEA Middle C PARISH		4 DATE OF DEATH Month NOVEMBER Day 19 Year 1967	
SEX FEMALE COLOR OR RACE WHITE		5 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
6. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		7. KIND OF BUSINESS OR INDUSTRY HOME	
8. DATE OF BIRTH 10/17/95		9. AGE (in years lost birthday) 72 yrs	
10. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		11. UNDER 1 YEAR Months Days Hours Min	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME OTTO HAFER		14. MOTHER'S MAIDEN NAME ANNIE KOHL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-07-0380B	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Malnutrition due to heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH 1967	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>due to</i>			
DUE TO (c) <i>lost</i>			
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21. I certify that (I) (this hospital) attended the deceased from <i>4/22/67</i> to <i>11/19/67</i> , that (I) (we) last saw the deceased alive on <i>11/16/67</i> , and that death occurred at <i>4:15 AM</i> . (Name causes and on the date stated above)	
22. SIGNATURE <i>R. J. Williams</i>		23. TIME OF INJURY Month Day Year Hour o'm p'm 19	
24. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
25. BURIAL, CREMATION, REMOVAL (Specify) Burial		20e. PLACE OF INJURY (Home, farm, factory, street off ce bldg, etc) <i>Cumt Alvy M</i>	
26. DATE THEREOF 11/22/1967		20f. (City or town) (County) (State)	
27. ADDRESS Greenmount Cemetery		22d. ADDRESS 122S. CENTRE ST., CUMBERLAND, MD.	
28. FUNERAL DIRECTOR <i>John J. Hafer Jr.</i>		23d. LOCATION (City or Town) (County) (State) <i>* Cumberland Alleg Md.</i>	
29. ADDRESS <i>230 Balto Ave. Cumberland</i>		25o. REC'D BY REG STRAR NOV 21 1967	
30. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm page 5 may be retained for your files.

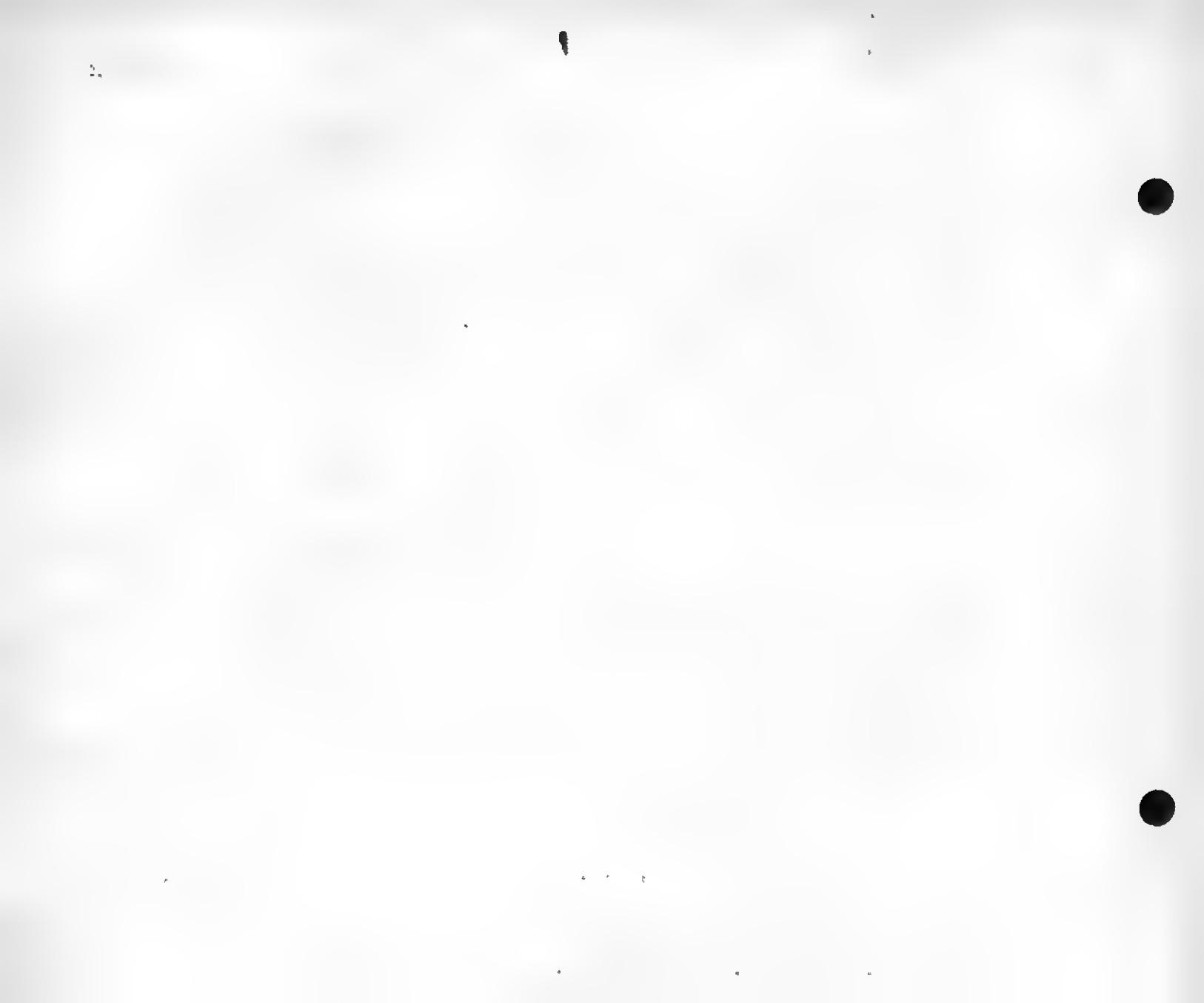
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14753

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN lb Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 Decatur Street			d. STREET ADDRESS 13 Decatur Street		
3. NAME OF DECEASED (Type or print) Ada Bell Parker			4. DATE OF DEATH Month November 29 1967		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1879		9. AGE (In years b. st birthday) 88 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) West Virginia		
13. FATHER'S NAME Henry Clem			14. MOTHER'S Maiden Name Alice Dawson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO		
17. INFORMANT Cumberland City Police Department			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden		
Coronary Sclerosis					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/1967		23c. NAME OF CEMETERY OR CREMATORIAL Camp Hill Cemetery	
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS John J. Hafer, Jr. 230 Baltimore Ave. Cumberland, Md.		23d. LOCATION (City, Town, County, State) Near Paw Paw, Hampshire, W Va.	
25a. REC'D BY REC'D. TO REC'D. REG'D. DEC 4 1967					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		M		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE	
ALLEGANY MARYLAND				PENNSYLVANIA b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 DAYS 9 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 1, ADDISON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL PEARY		4. DATE OF DEATH NOVEMBER 7 1967		Month Day Year	
5. SEX FEMALE WHITE		6. COLOR OR RACE WIDOWED DIVORCED		7. DATE OF BIRTH 11-4-67	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years lost birthday) yrs 10. KIND OF BUSINESS OR INDUSTRY		10. BIRTHPLACE (County & State, or foreign country) MEYERSDALE, PA	
11. FATHER'S NAME PAUL JAMES PEARY		12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME ALICE NICHOLSON	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		15. SOCIAL SECURITY NO.		16. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) i100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)		18. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Respiratory Failure Pneumonitis		19. INTERVAL BETWEEN ONSET AND DEATH	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22. MEDICAL CERTIFICATION	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 4:10 AM from causes and on the date stated above.		22. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 9, 1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR 404 Decatur St., Cumb. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

[†] the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
25M 1/67

14745

14755

CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14747

CERTIFICATE OF DEATH

14756

1 PLACE OF DEATH a. COUNTY Allegany County			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			b. COUNTY Allegany			
c. LENGTH OF STAY IN lb 89			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary			d. STREET ADDRESS 622 Elm Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Annie M. Peters			4. DATE OF DEATH Month Day Year November 4 1967			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1878	9. AGE (In years at birthday) 89 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Frost			14. MOTHER'S MAIDEN NAME Mary Drewnoski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No			16. SOCIAL SECURITY NO. 217-54-6513			
17. INFORMANT Harvey F. Peters			Address 613 N. Second Street LaVale, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial insufficiency			INTERVAL BETWEEN ONSET AND DEATH 35 minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension			DUE TO Arteriosclerosis			
(c) Chr 1.8. H.D.			DUE TO Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		
20f. (City or town) LaVale			(County) Carroll			(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Sept 27, 1965 , 19 to Nov. 4 , 1967, that (I) (we) last saw the deceased alive on Nov. 3 1967, and that death occurred at 5 p.m. M, from causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22o. SIGNATURE John A. Topper			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22b. DATE SIGNED Nov. 4-1967
22c. PHYSICIAN'S NAME (Type) John A. Topper MD			22d. ADDRESS Greenmount Hospital Cumberland, Md.			
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-6-67	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23d. LOCATION (City or Town) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR Silcox		ADDRESS 404 Decatur Street	25a. REC'D BY REGISTRAR Cumb. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
		DATE NOV 7 1967				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14748

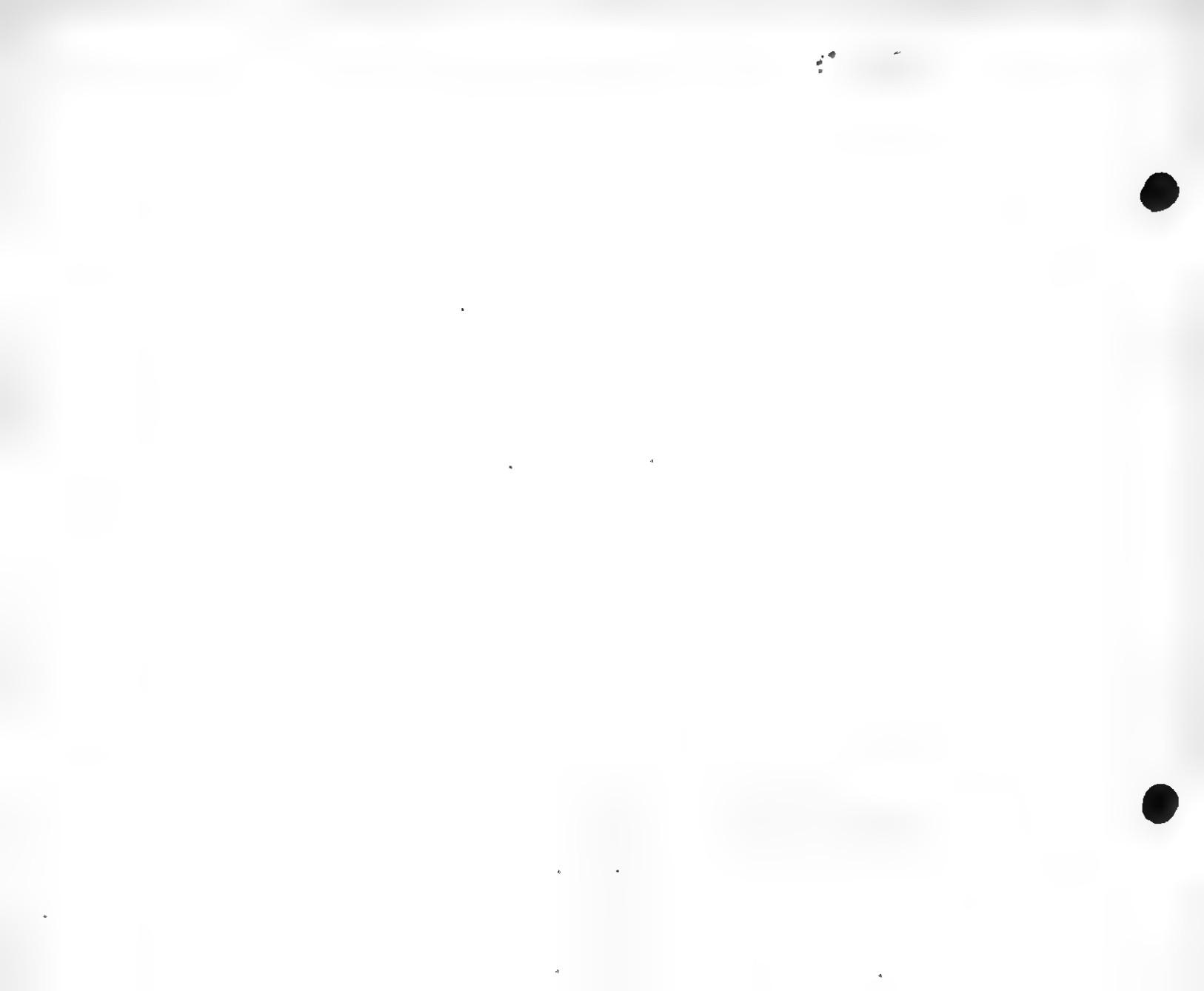
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14757

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Catherine Cecilia		First Catherine	Middle Cecilia
4 DATE OF DEATH November 25 1967	Month November	Day 25	Year 1967
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/> XX NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/4/1912
9 AGE (In years lost birthday) 55 yrs	10b KIND OF BUSINESS OR INDUSTRY Home	11 BIRTHPLACE (State or foreign country) Maryland	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Benjamin Quinn	14 MOTHER'S MAIDEN NAME Barbara Knapp	Address	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No	16 SOCIAL SECURITY NO 215-26-9578	17 INFORMANT C. Robert Pfaff	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis, generalized INTERVAL BETWEEN ONSET AND DEATH days 3/21			
DUE TO (b) Conditions, injury, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) Ruptured diverticulum of Sigmoid " "			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d INJURY OCCURRED When at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20c TIME OF INJURY Month Day Year hour am pm 19		20e PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 25, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/29/1967	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS Eckhart Methodist Cemetery	23d LOCATION (City or Town) (County) (State) Eckhart Alleg Md.
24 FUNERAL DIRECTOR John J. Hafer, Jr.	ADDRESS 230 Baileys Ave. Cumberland	25a REC'D BY REGISTRAR NOV 29 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burn, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14749		14758	
<p>1. PLACE OF DEATH a) COUNTY Allegany b) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland</p> <p>c) LENGTH OF STAY IN TO</p> <p>d) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital</p>		<p>2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a) STATE Maryland b) COUNTY Allegany</p> <p>c) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R-F-D- Frostburg, Md.</p> <p>d) STREET ADDRESS</p> <p>e) IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3 NAME OF DECEASED First George Middle W. Last Poland</p> <p>4 DATE OF DEATH 11/26/1967</p> <p>5 SEX Male COLOR OR RACE White</p> <p>6 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>7 KIND OF BUSINESS OR INDUSTRY Retired Coal Miner</p>		<p>Month Day Year</p> <p>8 DATE OF BIRTH 10/30/1879</p> <p>9 AGE (in years last birthday) 88 yrs</p> <p>10b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner</p> <p>11 BIRTHPLACE (State or foreign country) Barton, Md.</p> <p>12 CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13 FATHER'S NAME Manuel Poland</p>		<p>14. MOTHER'S MAIDEN NAME Nancet Clark</p>	
<p>15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16 SOCIAL SECURITY NO</p>	
<p>17 INFORMANT Mrs. Martha Glime, Frostburg, Md.</p>		<p>Address</p>	
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Chronic Myocarditis (c) Arteriosclerosis</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 3-4 days</p>	
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>Fracture of right hip</p>		<p>19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO XX</p>	
<p>20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH</p>		<p>20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home</p>	
<p>20c TIME OF INJURY Month, Day, Year Hour am 11:00 am Nov. 17 1967</p>		<p>20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></p>	
<p>20e PLACE OF INJURY (Home, farm factory, street, office building, etc.) Home</p>		<p>20f (City or town) Rt. 1 Frostburg, Alleg. Md. (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>		<p>22. DATE SIGNED November 26, 1967</p>	
<p>ACTUAL SIGNATURE Benedict Skitarelic, M.D.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.</p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>23a BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>DEPUTY MEDICAL EXAMINER XX</p>	
<p>23b DATE THEREOF 11/28/1967</p>		<p>Address (Street, city, town, or county) Cumberland, Maryland</p>	
<p>23c NAME OF CEMETERY OR CREMATORIAL Memorial Park</p>		<p>23d LOCATION (City or Town) (County) (State)</p>	
<p>24. FUNERAL DIRECTOR George Eichhorn</p>		<p>25a REC'D BY REGISTRAR Frostburg, Md.</p>	
<p>ADDRESS Lonaconing, Md.</p>		<p>25b REGISTRAR'S SIGNATURE Charles Judge</p>	
<p>DATE NOV 28 1967</p>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. *Then please remove carbon paper. Please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*

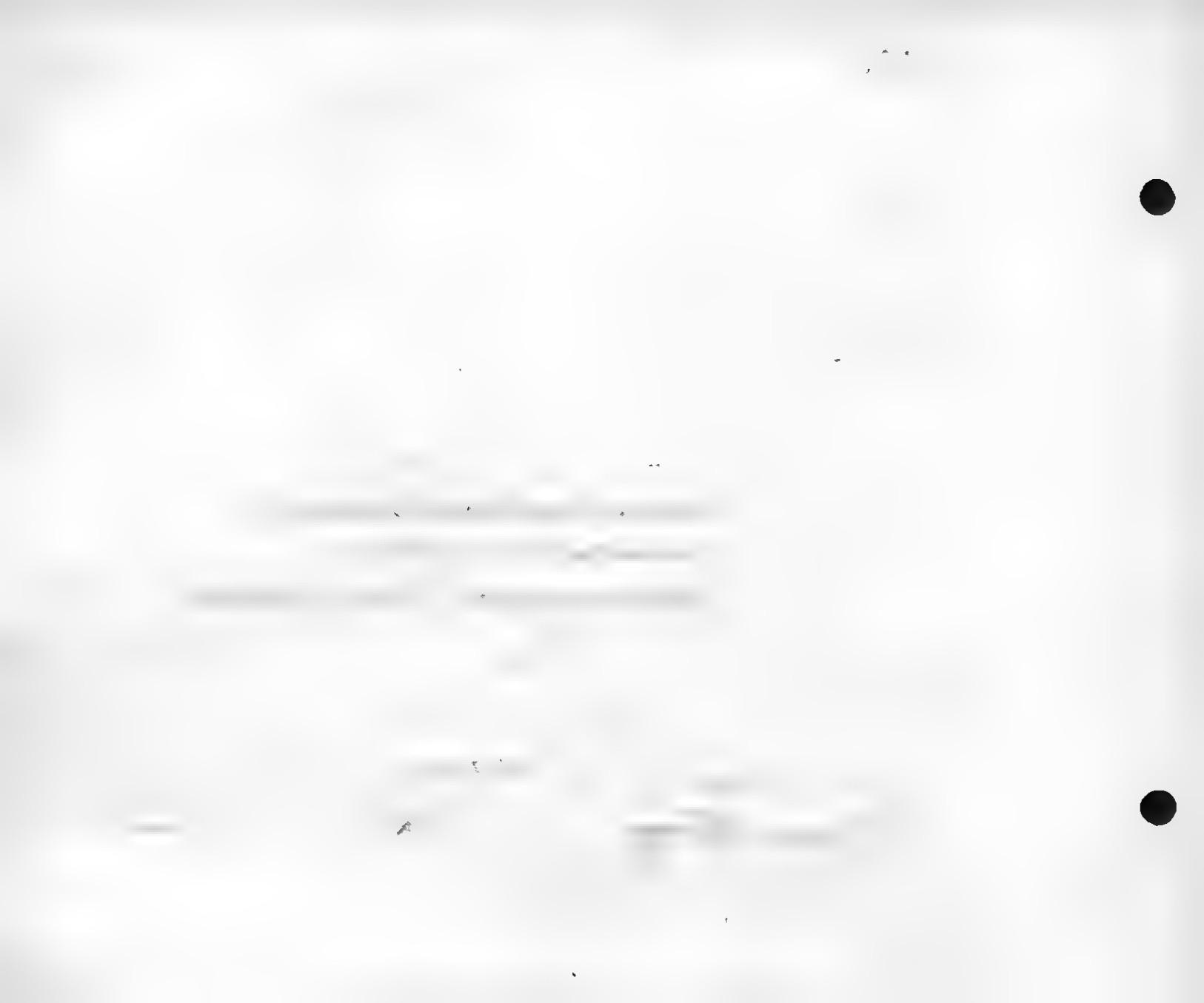
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G394 11/8/67 ph

14750

CERTIFICATE OF DEATH

14759

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 189 ORMOND STREET		d. STREET ADDRESS 189 ORMOND STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	FIRST JAMES	MIDDLE H.	4. DATE OF DEATH Month NOVEMBER Day 2, 1967 Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1888
9. AGE (In years) 79		9. DATE OF BIRTH 99 (last birthday) 79 1/2 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM PORTER		14. MOTHER'S MAIDEN NAME SARAH MATTHEWS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-10-2712-T	
17. INFORMANT MRS. HAZEL KEEDY, FROSTBURG, MD. 21532		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Advanced Myocardial Disease and</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a). Stating the underlying cause lost.			
(b) <i>Complete A-V Block</i>			
DUE TO (c) <i>Arteriosclerotic Heart Disease</i>		14yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 23, 1967 , to Nov. 2, 1967 , that (I) (we) last saw the deceased alive on Nov. 1, 1967 , and that death occurred at _____ M, from causes and on the date stated above.		22b. DATE SIGNED Nov. 2, 1967	
22a. SIGNATURE <i>G. Paige Strong</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 4 '67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE NOV. 6 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT!

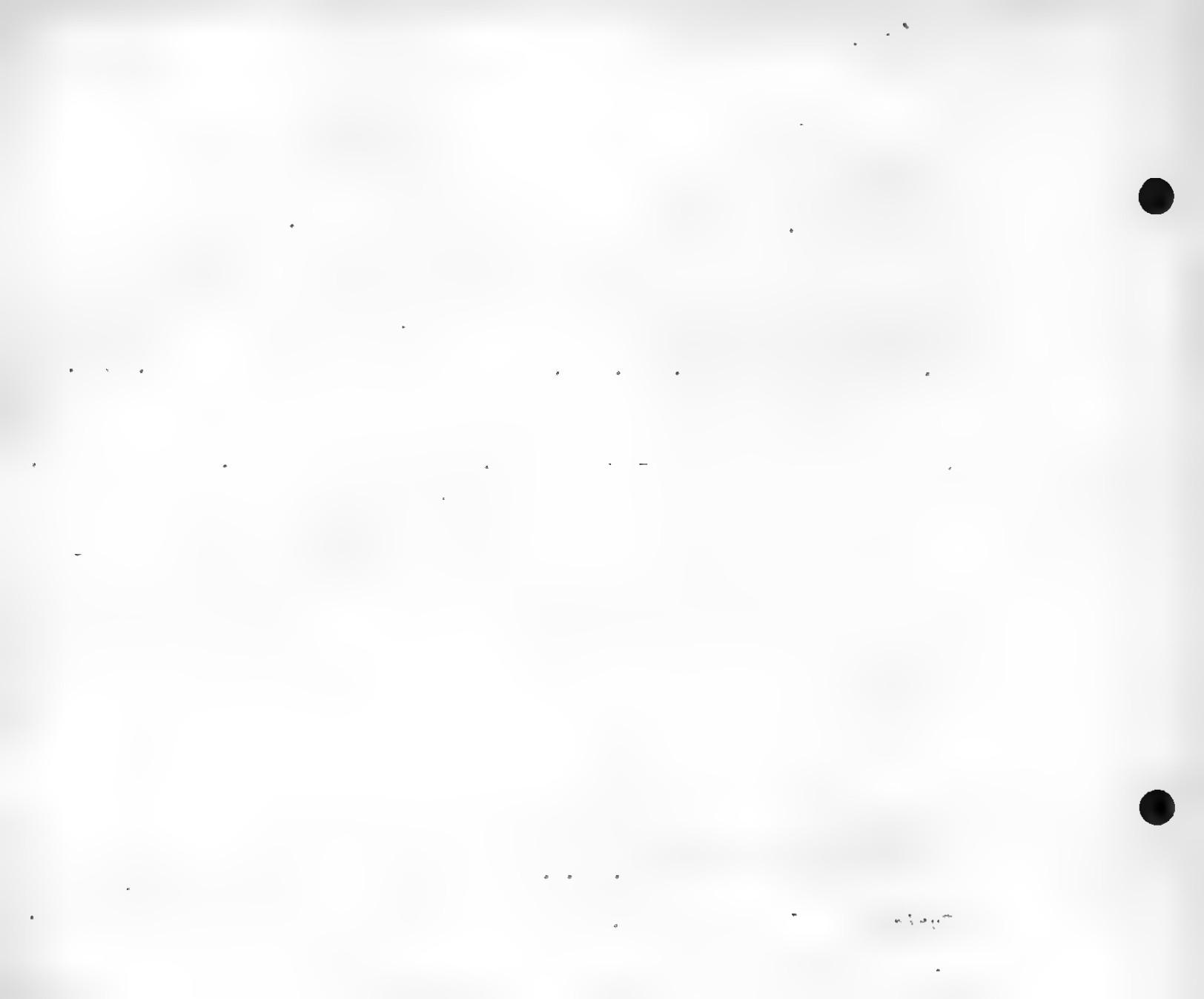
14751

14750

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland ,		d. STREET ADDRESS 233 Glenn St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 233 Glenn St.						e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albert		First	Middle	Last	4. DATE OF DEATH November 25, 1967	Month	Doy	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	W DIVORCED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 25, 1889	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Ry.		11. BIRTHPLACE (State or foreign country) Gibraltar, Spain		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Alberto Pou		14. MOTHER'S MAIDEN NAME Julia Rotundo							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 705-09-9004		17. INFORMANT Mrs. Ann Pou 233 Glenn St. Cumberland, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
		DUE TO CORONARY SCLEROSIS							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) Cumberland	(County) Allegany	(State) Md.	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Address (Street, city, town or county) CUMBERLAND, MARYLAND									
23a. BURIAL/CREMATION, Burial		23b. DATE THEREOF 11/28/67	23c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cemetery		23d. LOCATION (City, town, County, State) Cumberland, Allegany, Md.		23e. REG'D BY REGISTRAR DATE NOV 29 1967		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14752

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14761

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 15 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Burr		First Burr	Middle William
4. DATE OF DEATH Nov. 6 1967		5. STREET ADDRESS 45 Main St., Potomac Park	6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
7. SEX Male	8. COLOR OR RACE White	9. DATE OF BIRTH May 15, 1906	10. AGE (In years at birthday) 61 yrs
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Bus Driver	12. KIND OF BUSINESS OR INDUSTRY Public Transit	13. BIRTHPLACE (State or foreign country) Higginsville, W. Va.	14. CITIZEN OF WHAT COUNTRY? USA
15. FATHER'S NAME Charles Powell		16. MOTHER'S MAIDEN NAME Estella Powers	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO	
19. INFORMANT Mrs. Hazel Powell, Potomac Park, Wife		20. ADDRESS	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		22. INTERVAL BETWEEN ONSET AND DEATH Sudden	
4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO (c)		23. CORONARY SCLEROSIS DUE TO	
24. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
25a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18); 25c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
25d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		25e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
25f. (City or town) (County) (State)			
26. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
27. ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Nov. 6, 1967 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rt. 9 Cumberland	
29a. BURIAL, CREMATION, REMOVAL (Specify) Burial		29b. DATE THEREOF Nov. 8, 1967	
29c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park		29d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
29e. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		29f. REC'D BY REGISTRAR DATE NOV 8 1967	
		29g. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1
FOR STATE
HEALTH DEPT.
14753

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. Zone 5 may be retained for your files.

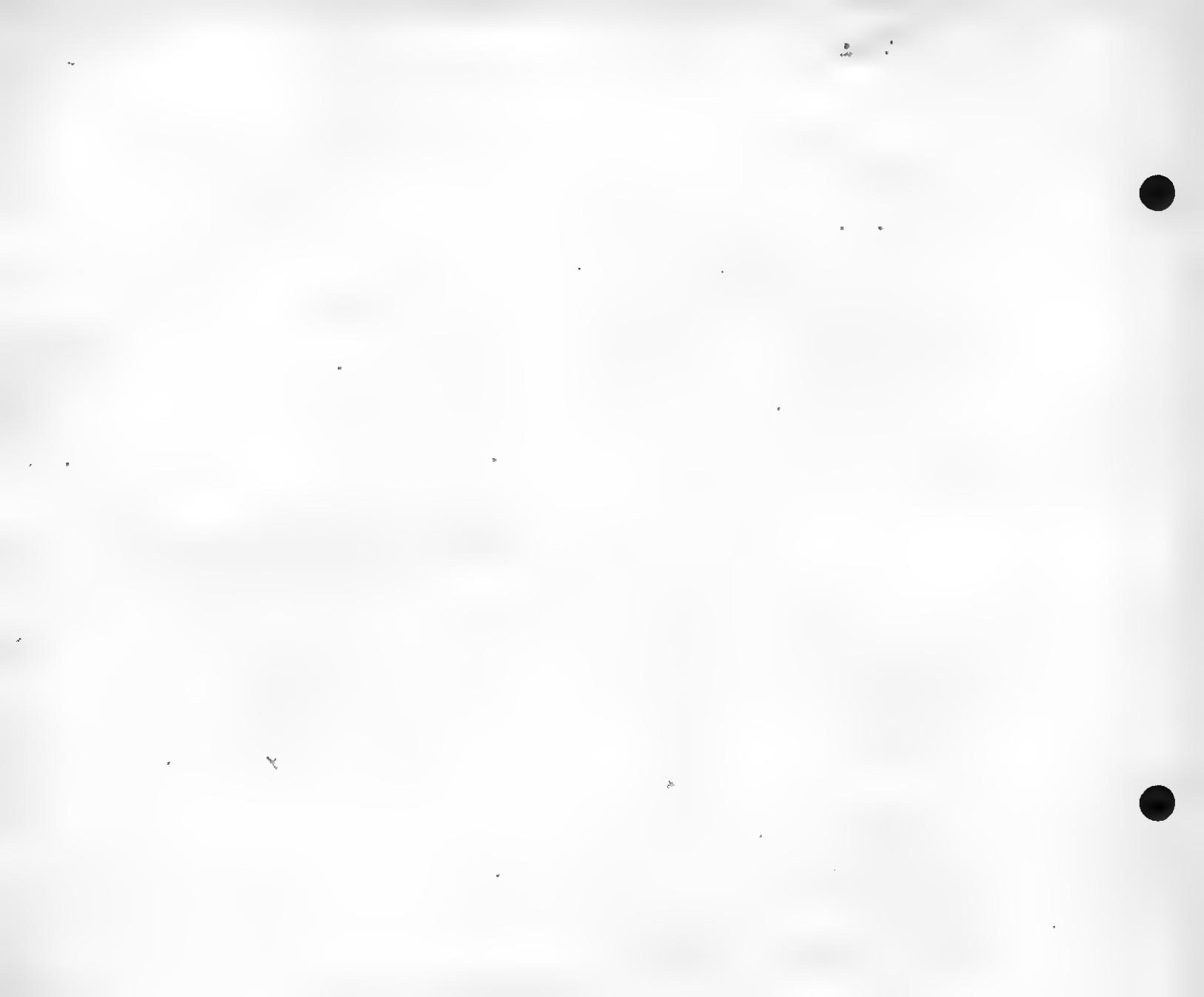
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14762

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE W. Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Mineral	
c. LENGTH OF STAY IN MD ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		d. STREET ADDRESS Carpenters Addition	
e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle Harry	Last Powell
4. DATE OF DEATH Month Nov.	Day 15	Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED X NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>
B. DATE OF BIRTH July 5, 1909	9. AGE (In years last birthday) yrs 58	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker	10b. KIND OF BUSINESS OR INDUSTRY Tire Industry	11. BIRTHPLACE (State or foreign country) Augusta, W. Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James H. Powell	14. MOTHER'S MAIDEN NAME Virginia Saville		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Richard D. Powell, Wiley Ford, W. Va.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4101 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			
Coronary Occlusion			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 11-15-1967 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		22. DATE SIGNED Address (Street, city, town, or county) Rt. 9 Cumberland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 18, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery
23d. LOCATION (City or Town) (County) (State)		23e. ADDRESS Augusta, W. Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 22 1967	25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and, if any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 22 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (First Middle Last Name) MARY FRANCES ROONEY		4 DATE OF DEATH Month 11 Day 23 Year 1967	
5 SEX FEMALE		6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY HEALTH DEPT.	
11 BIRTHPLACE (County & State of birth) LONACONING, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LAWRENCE ROONEY		14. MOTHER'S MAIDEN NAME MARGARET (FLYNN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. 213-24-6586	
17. INFORMANT HOSPITAL RECORD, SETON DRIVE, CUMB., MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 7545		4. INTERVAL BETWEEN DEATH AND DEATH 4 WEEKS	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) (c)		CONGESTIVE HEART FAILURE	
		CONGENITAL VALVULAR HEART DISEASE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) MARFAN'S SYNDROME		41 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 - 5, 1965 , to 11 - 23, 1967 , that (I) (we) last saw the deceased alive on 23, 1967 , and that death occurred at 7P M, from causes and on the date stated above		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST. CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/1967	
24. FUNERAL DIRECTOR George Eichhorn		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Marys Cemetery Lonaconing, Md.	
25a. REC'D BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE OTL and Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14755

CERTIFICATE OF DEATH

14764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 2 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS BOX 161 MEADOW VIEW DR.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First CHRISTOPHER	Middle ALLEN	Last SHEPHERD			
4. DATE OF DEATH	Month NOVEMBER	Day 28 ₁₉	Year 67			
5. SEX m	6. COLOR OR RACE w	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		9. DATE OF BIRTH 11-26-67				
10a. KIND OF BUSINESS OR INDUSTRY ----		9. AGE (In years last birthday) 2 DAYS				
11. BIRTHPLACE (County & State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME LOUIS A. SHEPHERD		14. MOTHER'S MAIDEN NAME CAROL L. RIGGLEMAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO ---				
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. (c)		Respiratory Failure Pre maturity				
		INTERVAL BETWEEN ONSET AND DEATH				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 1945 to 1950 P.M., 19____, that (I) (we) lost sow the deceased alive on _____, 19____, and that death occurred at _____, M., from causes and on the date stated above.						
22a. SIGNATURE <i>Robert Brodell</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL		22d. ADDRESS CUMBERLAND, MD.				
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11/30/67	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) Cumberland, Allegany, Md.	(County)	(State)	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR DEC 4 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14756

14765

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 27
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 16 18 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL		d. STREET ADDRESS 711 MONTGOMERY AVE.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First VIRGINIA Middle		4. DATE OF DEATH Month Day Year SHIRCLIFF NOVEMBER 17, 1967	
5. SEX FEMALE 6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND - CUMBERLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME WILLIAM GARRETT		14. MOTHER'S MAIDEN NAME MYRTLE HECK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-40-3674	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7040 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Lymphatic Leukemia Intestinal Hemorrhage 1 day Pneumonia R. Lung 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1967, to 7 A.M., 1967, that (I) (we) last saw the deceased alive on Nov. 17, 1967, and that death occurred at M, from causes and on the date stated above			
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL PARK Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS ADDRESS 25b. REC'D BY REG. STRR. DATE NOV 22 1967	
		25b. REGISTRAR'S SIGNATURE <i>John F. Justice</i>	



FOR STATE
HEALTH DEPT.

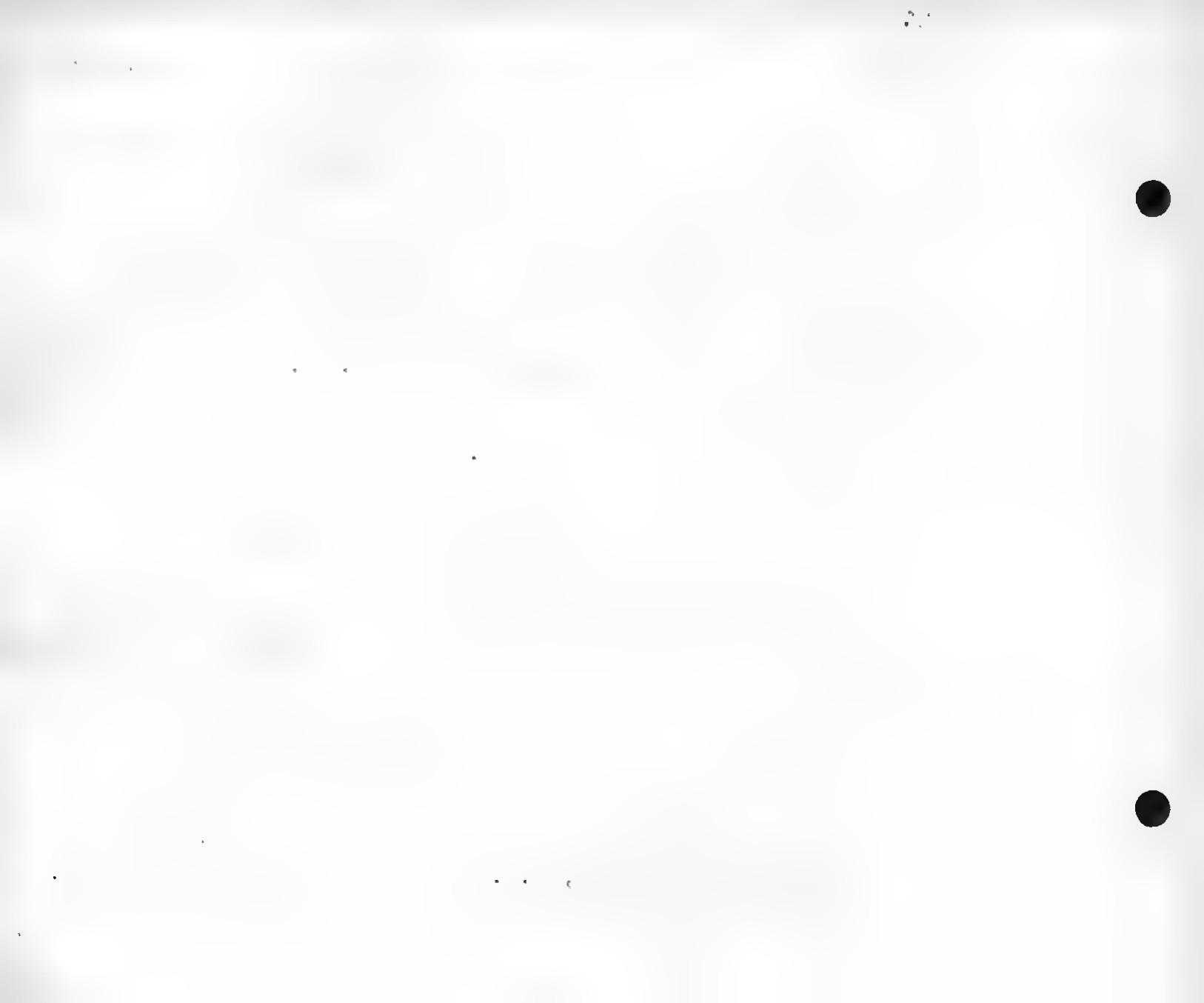
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14757		14766	
1 PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c LENGTH OF STAY IN lb 36 years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 913 Louisiana Avenue		d STREET ADDRESS 913 Louisiana Avenue	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Peter William Smith		First Peter	Middle William
Last Smith		4 DATE OF DEATH Nov. 24 1967	Month Year Day Year
5 SEX Male	6 COLOR OR RACE White	7 MARR ED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH Feb. 27, 1917
9 AGE (In years last birthday) 50 yrs		10a USL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b KIND OF BUSINESS OR INDUSTRY Railroad
11 BIRTHPLACE (State or foreign country) Thoms, W. Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Frank Smith		14 MOTHER'S MAIDEN NAME Ruby Bergstrom	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	17 INFORMANT Address Mrs. Diane Smith, Cumberland, Md. Wife
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tou DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN DEATH AND DEATH Sudden	
Coronary Occlusion		Coronary Sclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b); 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm factory, street, office bldg. etc.) 20f (City or town) (County) (State)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Nov. 24, 1967 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		22. DATE SIGNED Nov. 24, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		23a BURIAL, CREMATION REMOVAL (Specify) REMAINS TAKEN TO ANATOMICAL BOARD UNIVERSITY OF MD. BALTIMORE, MD.	
23b DATE THEREOF REMAINS TAKEN TO ANATOMICAL BOARD UNIVERSITY OF MD. BALTIMORE, MD.		23c NAME OF CEMETERY OR CREMATORIAL REMAINS TAKEN TO ANATOMICAL BOARD UNIVERSITY OF MD. BALTIMORE, MD.	
24. FUNERAL DIRECTOR ADDRESS James P. Scappelli, Cumberland, Md.		23d LOCATION (City or Town) (County) (State) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE NOV 27 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

INTO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires, that the death certificate be executed within 24 hours after death.

IF THE DEATH OCCURS IN A HOSPITAL OR ATTENDING PHYSICIAN'S OFFICE: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

14767

1 PLACE OF DEATH a. COUNTY ALLEGANY			2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			d. STREET ADDRESS 314 COLUMBIA STREET		
3 NAME OF DECEASED (Type or print) HELEN V.		First Middle		4. DATE OF DEATH 11	Month Day Year -07 19 67
S SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-87	9 AGE (in years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a US. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) WESTERNPORT, MARYLAND	
13. FATHER'S NAME JOHN Mc Partland			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-05-6181		17. INFORMANT MARY (HALFPENNY) Address HOSPITAL RECORD - 200 SETON DRIVE, CUMB.	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) APLASTIC ANEMIA			INTERVAL BETWEEN ONSET AND DEATH		
+ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CORONARY INSUFFICIENCY					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21 I certify that (I) (this hospital) attended the deceased from 5-20, 1967, to 11-7, 1967, that (I) (we) last saw the deceased alive on 11-7, 1967, and that death occurred at 8P M, from causes and on the date stated above					
22a SIGNATURE <i>R. W. Ballin, M.D.</i>			22b DATE SIGNED 11-9-67		
22c. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST., CUMB., MD. 21502			
23a BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL		23b DATE THEREOF Nov. 10, 1967		23c NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	
23d LOCATION (City or Town) Cumberland Allegany Md.		(County) (State)			
24. FUNERAL DIRECTOR JAMES SCARPELLI		ADDRESS 108 VA. AVE. CUMB. MD.		25a REC'D BY REGISTRAR NOV 13 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

14758		14768	
1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 2 DAYS 2 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 1110 FREDERICK STREET	
3 NAME OF DECEASED (Type or print) MERNIE		First MIDDLE STEINLA	4 DATE OF DEATH Month NOVEMBER Day Year 15 1967
5 SEX FEMALE		6 COLOR OR RACE WHITE	
7 MARRIED WIDOWED X		8 NEVER MARRIED DIVORCED □	
9. DATE OF BIRTH 8-13 04		10. AGE (In years lost birthday) 63 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) W. VA. Petersburg	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE C. OURS	
14. MOTHER'S MAIDEN NAME FLORENCE KISAMORE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO 215-48-0225		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 7100 IMMEDIATE CAUSE (a) <i>Terminal malnutrition and cardiac failure</i> INTERVAL BETWEEN ONSET AND DEATH 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Siderodermia, generalized, H. I. least most involved</i> 2 years (c)			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 1b) <i>A.S. Cardioradulitis disease with gen. arteriosclerosis</i>	
20c. TIME OF INJURY Month, Day, Year Hour 'o' m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 July 1967 to 15 Nov. 1967 that (I) (we) last saw the deceased alive on 14 Nov. 1967 , and that death occurred at 3:50 AM from causes and on the date stated above			
22a. SIGNATURE <i>W. A. Van Ormer.</i>		22b. DATE SIGNED 16 Nov. 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-17-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR H. Lee Silcox 404 Decatur St., Cumb., Md.		25a. REC'D BY REGISTRAR DATE NOV 20 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT

Health Dept. on
form PM3. Page

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14760 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14769

1 PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Maryland		c. LENGTH OF STAY IN LD 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital, Frostburg		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
f. STREET ADDRESS 12 East College Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Margaret		First E.	Middle Stephenson
4 DATE OF DEATH 11	Month 25	Doy 19	Year 67
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 16, 1887
10a. USUA. OCC.PATION (Give kind of work done during most of working life, even if retired) Retired-Bobbin room		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	9 AGE (in years lost birthday) 80 yrs
13 FATHER'S NAME Samuel Stephenson		14. MOTHER'S MAIDEN NAME Ellen Clise	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service		16 SOCIAL SECURITY NO. 215-20-6846-A	17 INFORMANT John E. Stephenson, Baltimore, Md., 21234
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		Coronary Thrombosis, Right Coronary Sclerosis	
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 26, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28 1967	23c. NAME OF CEMETERY OR CREMATORIAL Fbg. Memorial Park
23d. LOCATION (City or Town) (County) (State)		23e. ADDRESS Frostburg, Md.	
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532		25a. REC'D BY REGISTRAR DEC 1 1967	25b. REGISTRAR'S SIGNATURE <i>James J. Geary</i>
VR A15ME (5) 6M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 21 E. Main St., Frostburg, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Chester		First	Middle	Last	4. DATE OF DEATH	Month	Day Year
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1905	9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (County & State, or foreign country) Eckhart, Allegany Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Stewart				14. MOTHER'S MAREN NAME Nellie Myers Address Frostburg, Md.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 215-10-4481		17. INFORMANT Daughter - Sally Blane		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to Nov 17, 1967, that (II) (we) last saw the deceased alive on 13 Nov 1967, and that death occurred at 1504 M, from causes and on the date stated above.							
22a. SIGNATURE L. Michael Glick				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS 126 ... Sunnwood St., Camb., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-19-67		23c. NAME OF CEMETERY OR CREMATORIAL REST LAWN MEMORIAL GARDENS		23d. LOCATION (City or Town) (County) (State) GUMPLAND, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. ADDRESS 21532				25a. REC'D BY REGISTRAR		25b. REG STRR'S SIGNATURE DATE NOV 21 1967 Michael Glick	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14762

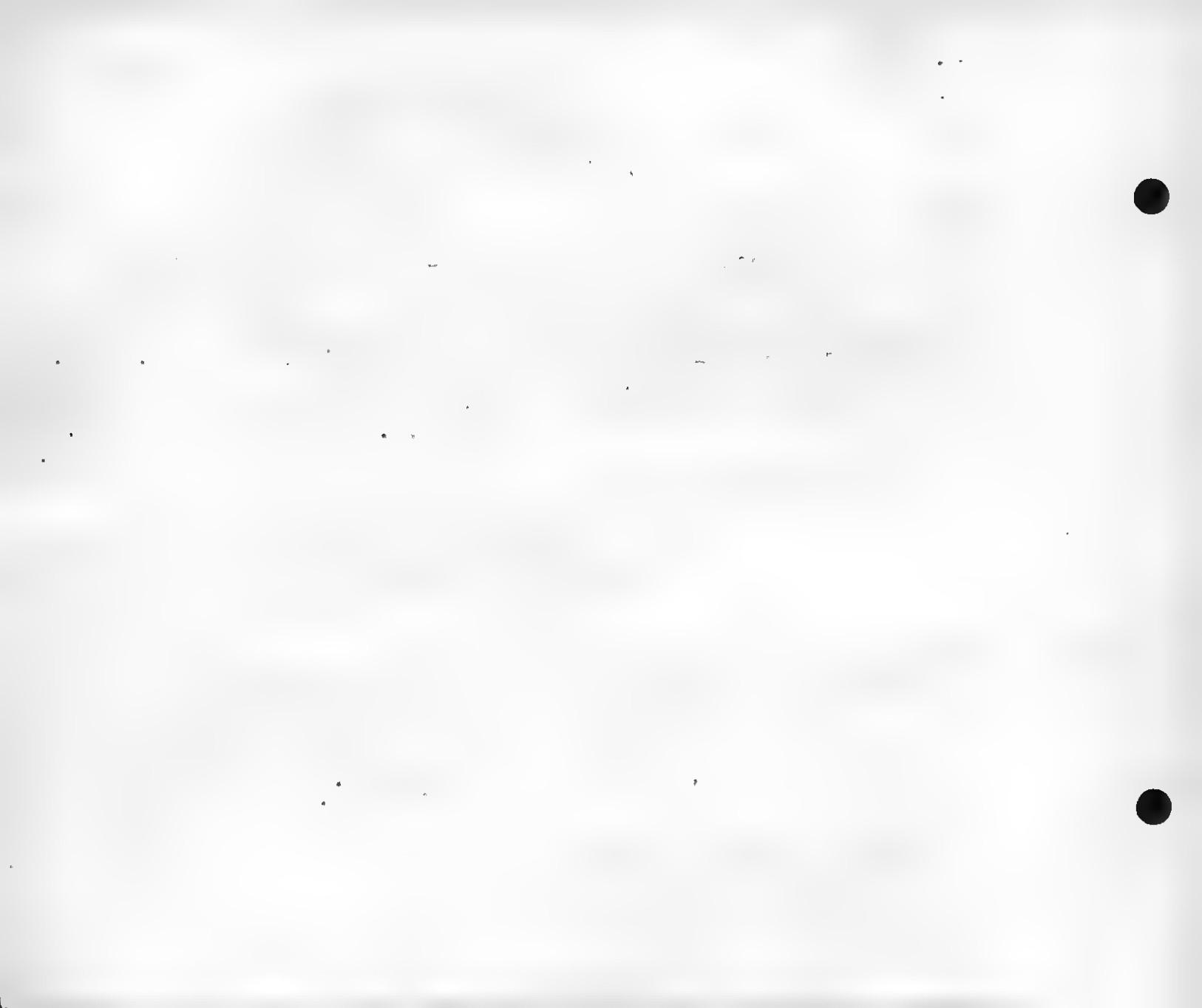
CERTIFICATE OF DEATH

16278

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/5/1967	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 128 Oak Street	
3. NAME OF DECEASED (Type or print) John Michael Taylor		4 DATE OF DEATH Month November Day 28, Year 1967	
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVDRCED <input type="checkbox"/>
9. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Blacksmith-Proprietor		B. DATE OF BIRTH 8/5/1876	
10. KIND OF BUSINESS OR INDUSTRY Blacksmith-Proprietor		9. AGE (In years last birthday) 91 yrs	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James William Taylor		14. MOTHER'S MAIDEN NAME Emma Florence Click	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. P.O. Box 599, Cumberland, Md.	
17. INFORMANT Allegany County Infirmary records.		18. INTERVA. BETWEEN ONSET AND DEATH after the	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) Ch. A.S.C.V. with atrioventricular fibrillation DUE TO (c) Arterio sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema		21. WAS A MEDICAL CERTIFICATION ON	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B. DUE TO <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, not fit for MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) at 8:55 P.M.	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. July 5, 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Memorial Hospital, Cumberland, Md.
21. I certify that (I) (this hospital) attended the deceased from July 5, 1967 , to Nov. 28, 1967 , that (I) (we) last saw the deceased alive on Nov. 28, 1967 , and that death occurred at P.M. from causes and on the date stated above.		22b. DATE SIGNED Nov. 29, 1967	
22a. SIGNATURE John A. Tepper		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
22c. PHYSICIAN'S NAME (Type) John A. Tepper		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 12-1-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Springfield Hill	
24. FUNERAL DIRECTOR Ruth Shaffer Romney W. Va.		25a. RECEIVED BY REGISTRAR DATE DEC 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles George	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

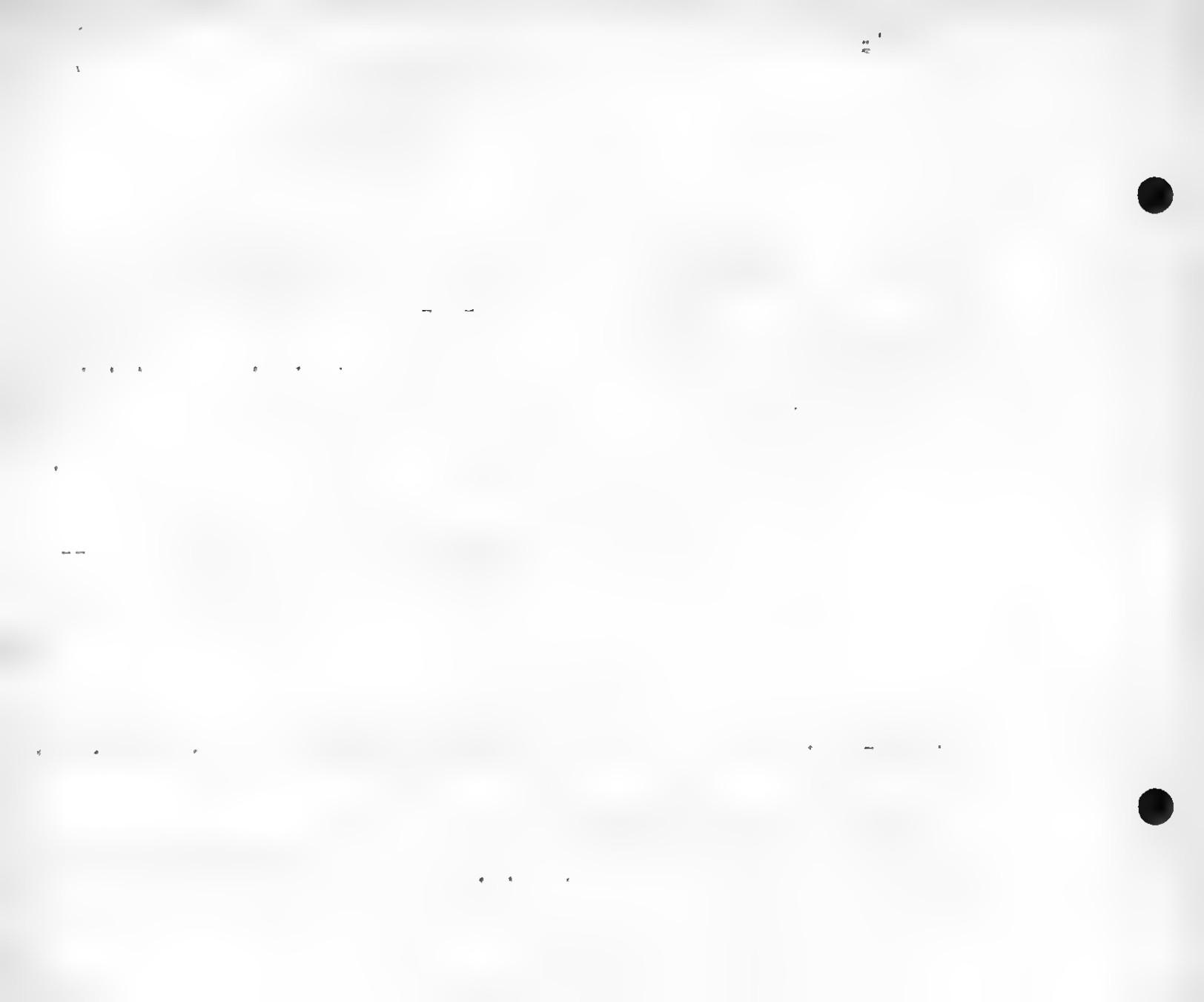
14771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1
14763
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb /	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital 3½ days		e. STREET ADDRESS 13 Arch Street	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH November 21 1967	
3. NAME OF DECEASED (Type or print) William H Troutman		First W	Middle H
4. SEX Male		5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/>
7. NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-1870	
9. AGE (In years last birthday) 97		10. IF UNDER 1 YEAR Months 0	
11. IF UNDER 24 HRS Days 0		12. IF UNDER 24 HRS Hours 0	
10. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY Blacksmith Own Home Railroad Wheeling, W.Va.	
13. FATHER'S NAME Frank Troutman		14. MOTHER'S MAIDEN NAME Susan Robinette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 705-05-1674	
17. INFORMANT Memorial Hospital-Cumberland, Md.		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis		19. INTERVAL BETWEEN ONSET AND DEATH Months ---	
DUE TO Arteriosclerotic cardiovascular disease			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost			
(b)			
DUE TO Intertrochanteric fracture of Left Femur			
(c)			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in kitchen of his home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:30 Nov. 18 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or Town) Cumberland, Alleg. Md.	
20g. (County) Cumberland, Maryland		(State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED November 21, 1967	
ACTUAL SIGNATURE <i>Benedict Skitarelic, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS	
25b. REC'D BY REGISTRAR NOV 27 1967		25c. REGISTRAR'S SIGNATURE <i>Glenda Judge</i>	
VR AT SME (6M 1/67)		DATE	

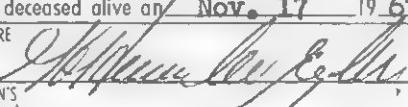


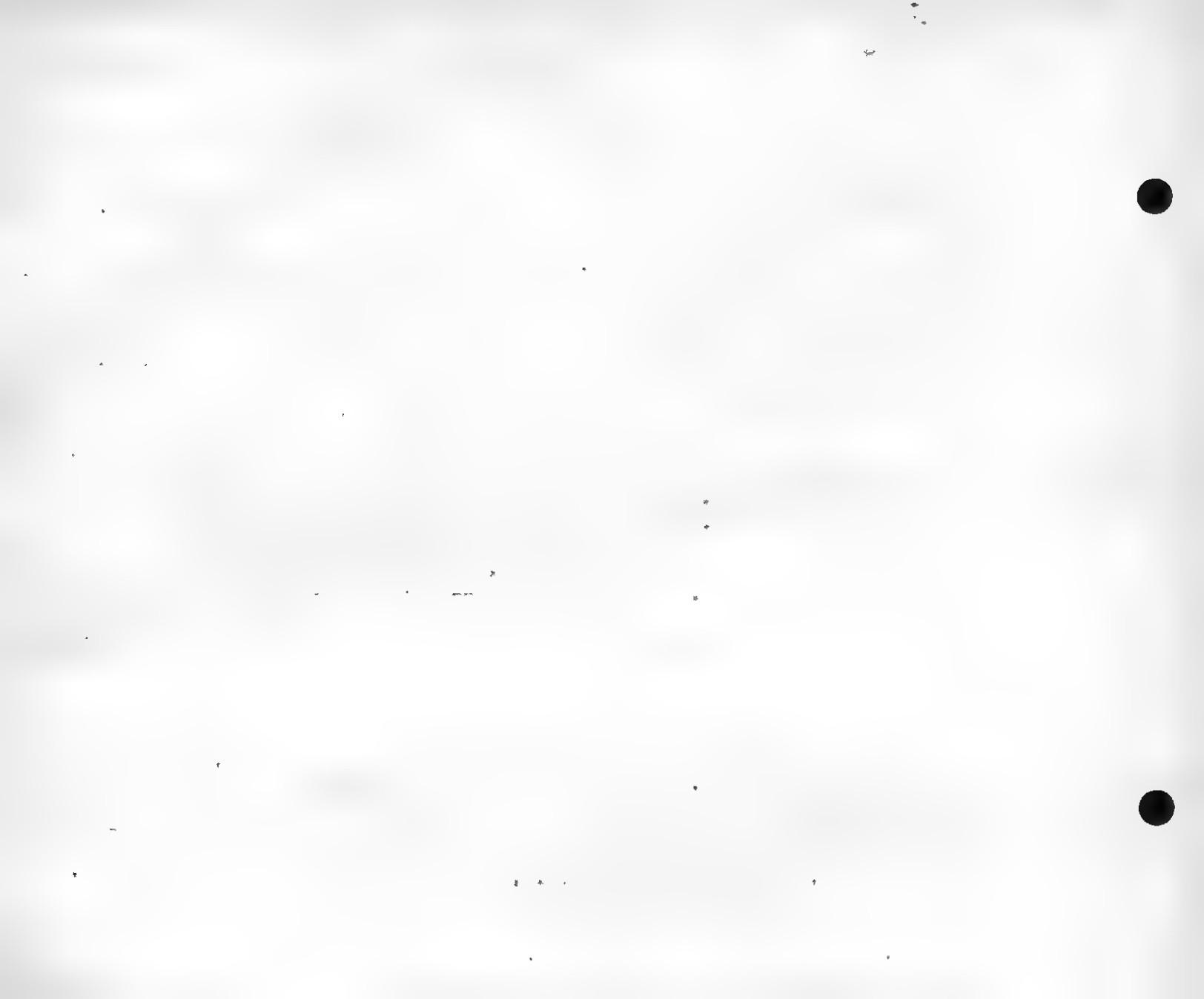
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers (page 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #4, BRICE HOLLOW RD.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FEMALE ETHEL		First MIDDLE PEARL	Last TWIGG	
4. DATE OF DEATH NOVEMBER 17, 1967.		Month	Day Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-19-1901		9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME JOHN E. VALENTINE		14. MOTHER'S MAIDEN NAME MINNIE C. WILSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO None	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) f201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		1. Massive Pulmonary Embolism with Coronary Occlusion seconds		
DUE TO (b) Arteriosclerotic Cardiovascular Disease with Adrenal Adenoma.		2. Hypertensive Cardiovascular Disease due to		
DUE TO (c) Chronic Hepatitis--Pancreatitis-Acute		3. Chronic Hepatitis--Pancreatitis-Acute		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Viral Infection with dehydration and Gastroenteritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1954, 19, to Nov., 1967, that (I) saw the deceased alive on Nov. 17, 1967, and that death occurred at 11:15A.M. from causes and on the date stated above.		22b. DATE SIGNED 11-18-67		
22a. SIGNATURE 		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS 133 Virginia Ave., Cumberland, Md.	
22c. PHYSICIAN'S NAME (Type) Overton Himmelwright, M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/67	23c. NAME OF CEMETERY OR CREMATORIAL BURIAL PARK Davis Memorial Burial Park	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR NOV 22 1967	
			25b. REGISTRAR'S SIGNATURE Charles Juge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If at all necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14765

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14773

1. PLACE OF DEATH

e. COUNTY

Allegany

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cumberland--MD

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Memorial Hospital (1 hr. 40 Min)3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

November 5

1967

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

3-17-50

10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Ft. Hill High School**Maryland****U.S.A.**

C.

14. MOTHER'S MAIDEN NAME

Martha Frey

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

None

Memorial Hospital-Cumberland, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1164

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

cause last.

(c)

Hemothorax, Right**Compression of Chest****(Automobile Accident)**INTERVAL BETWEEN
ONSET AND DEATH
2 hrs.**2 hrs.**

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

Deceased a passenger in right rear seat involved in crash

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

12:10 Nov. 5 1967

While at work

Not While at work

K

Street

Cumberland, Alleg. Maryland21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

November 5, 1967

Address (Street, city, town, or county)

Cumberland, Maryland

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial

Nov. 8, 1967

Mt. Pleasant Cemetery

Allegany County

Md.

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D. BY REGISTRAR

24d. REGISTRAR'S SIGNATURE

John J. Hafer

John J. Hafer, Jr., 230 Balto Ave.

Cumberland, Md.

NOV 8 1967

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14765

CERTIFICATE OF DEATH

14774

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN b. 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 10 E. MAPLEVIEW TERR.	
f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAUDE	Middle HELEN	4. DATE OF DEATH Month NOVEMBER 30, 1967
S SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) BRADDOCK, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK W. CHRISTMAN		14. MOTHER'S MAIDEN NAME ANNA E. SKIDMORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) NO		16. SOCIAL SECURITY NO N.A.	
17. INFORMANT MRS. JOHN VILLA, HOPE ROAD, FROSTBURG		Address MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH yr - yr -	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic eve -			
(c) Hypertension -			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uncontrolled Diabetes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) X	
20c. TIME OF INJURY Month, Day, Year Hour o.m. X 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) X (County) ALLEGHENY CO. (State) PA.	
21. I certify that (I) (this hospital) attended the deceased from 11/28, 1967 , to 11/30, 1967 , that (I) (we) last saw the deceased alive on 11/30, 1967 , and that death occurred at 12:35 P.M. , from causes and on the date stated above			
22a. SIGNATURE Martin M. Rothstein		22b. DATE SIGNED 12/1/67	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/5/67	
23c. NAME OF CEMETERY OR CREMATORIAL JEFFERSON MEMORIAL CEM.		23d. LOCATION (City or Town) (County) (State) ALLEGHENY CO., PA.	
24. FUNERAL DIRECTOR MARY LOU M. SOWERS HAFER-SOWERS FUNERAL HOME		25a. ADDRESS 60 W. MAIN, FROSTBURG, MD.	
25b. REC'D BY REGISTRAR DEC. 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						14775		
1. PLACE OF DEATH a. COUNTY ALLEGANY			b. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			d. STREET ADDRESS 233 E. MAIN ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES		First C.	Middle WIEBRECHT	Lost	4 DATE OF DEATH NOVEMBER 25 1967	Month NOVEMBER	Doy 25	Year 1967
5. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-06	9. AGE IN years 61 (last birthday) yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) SERVICE STATION MGR...		10b. KIND OF BUSINESS OR INDUSTRY SERVICE STATION		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD. (ALLEGANY)		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CONRAD WIEBRECHT			14. MOTHER'S MAIDEN NAME MITCHELL					
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-3815		17. INFORMANT HOSP. RECORD		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1051 DUE TO Liver metastasis, Bone metastasis, lymphoma						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Bronchogenic carcinoma (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form factory, street, office bldg, etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above								
22a. SIGNATURE <i>Clarence J. Vincent</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1967		
22c. PHYSICIAN'S NAME (Type) CLARENCE J. VINCENT		22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-28-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART ALLEGANY, MD.		
24. FUNERAL DIRECTOR DURST FUNERAL HOME		25a. REC'D BY REG STRR DATE DEC 1 1967 25b. REGISTRAR'S SIGNATURE Charles J. Durst						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 39 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL 900 SETON DRIVE, CUMB., MD. 21502		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTON, MD.	
3. NAME OF DECEASED First HELENA Middle I. WILMOTH Last		4. DATE OF DEATH Month NOVEMBER Day 1 Year 1967	
5. SEX FEMALE COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-17-27		9. AGE (In years last birthday) yrs 40	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF.		11. BIRTHPLACE (County & State, or foreign country) CRESAPTON, MD.	
13. FATHER'S NAME ALBERT LEASE		14. MOTHER'S MAIDEN NAME MARY CHILCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-24-5795	
17. INFORMANT HOSPITAL CHART		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X DUE TO <i>Cancer of the pancreas</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 months	
19. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERRINGING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-22-1967, to 11-1-1967, that (I) (we) last saw the deceased alive on 11-1-1967, and that death occurred at M, from causes and on the date stated above		22b. DATE SIGNED 11-2-67	
22a. SIGNATURE <i>G. Brings</i>		22d. ADDRESS 57 GREENE STREET, CUMB., MD. 21502	
22c. PHYSICIAN'S NAME (Type) L. BRINGS, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/1967	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md/	
24. FUNERAL DIRECTOR <i>John J. Hafer Jr.</i> , ADDRESS 230 Balto Ave. Cumberland, Md.		25a. REC'D BY REG STRR NOV 6 1967	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



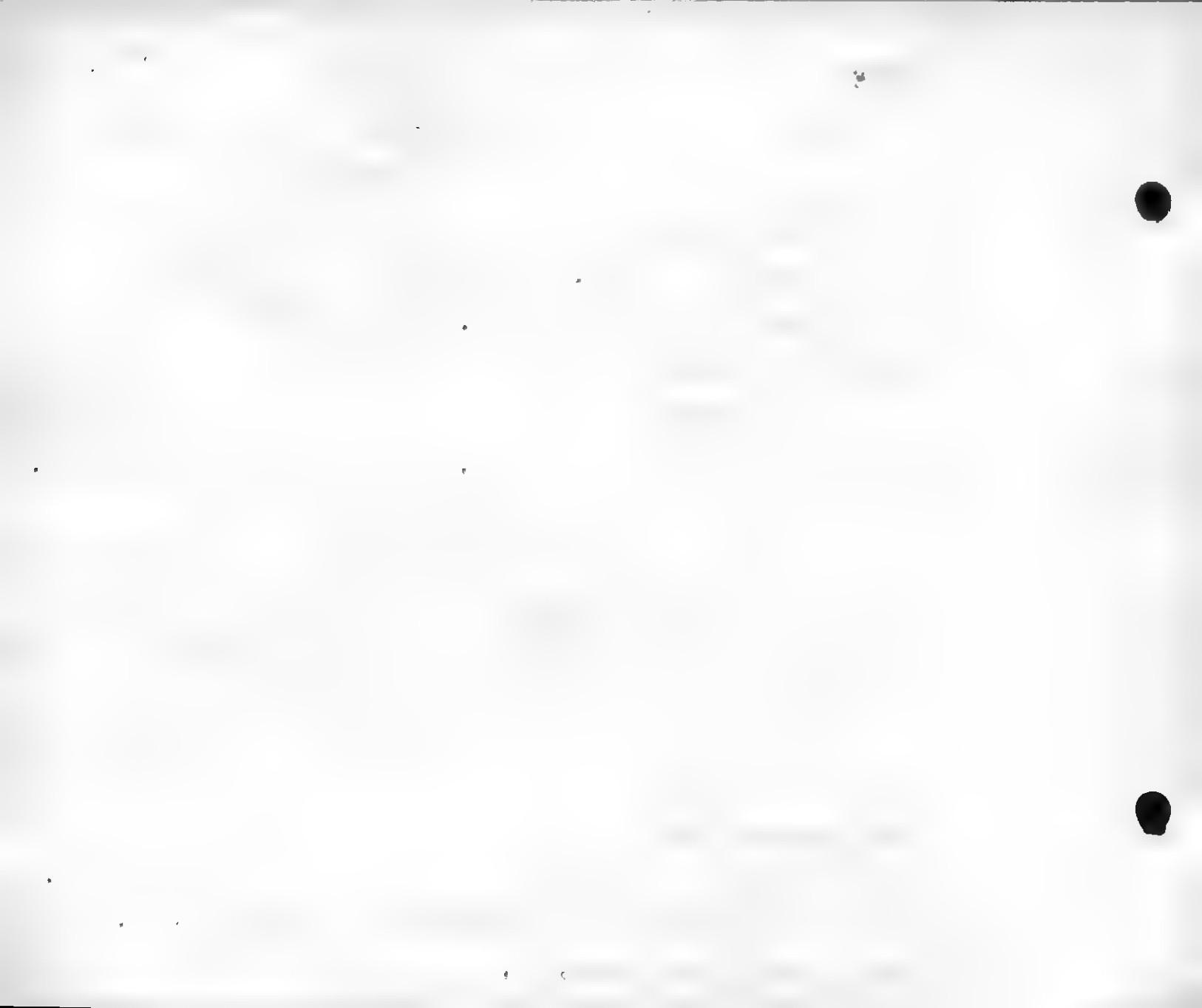
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14777	
1 PLACE OF DEATH O. COUNTY Allegany b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland b. COUNTY Allegany							
c LENGTH OF STAY IN lb 320 Furnace Street						c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland							
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 320 Furnace Street						d STREET ADDRESS 320 Furnace Street						e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Leonard		First D.	Middle	Last Wilson	4 DATE OF DEATH 11/13/1967		Month 11		Day 13		Year 1967		
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/7/1884		9 AGE (in years last birthday) 82 yrs		10 UNDER 1 YEAR Months 0		11 UNDER 24 HRS Days 0 Hours 0 Min 0			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner				10b KIND OF BUSINESS OR INDUSTRY				11 BIRTHPLACE (State or foreign country) England				12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Robert Wilson						14 MOTHER'S MAIDEN NAME Bessie Hatherley							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16 SOCIAL SECURITY NO			17 INFORMANT Mrs. Kirby Miller, Cumberland, Md. (Daughter)			Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY OCCLUSION INTERVAL B/W ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) CORONARY SCLEROSIS (c) -----													
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19									
20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>				20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)				20f (City or town) Lonaconing (County) W.M.D. (State)					
21 I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.													
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 11/15/1967		23c NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		23d LOCATION (City or Town) Lonaconing (County) W.M.D. (State)							
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md.		ADDRESS		25a REC'D BY REGISTRAR NOV 15 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR A15ME (5) 6M 1/67													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14778

CERTIFICATE OF DEATH

14778

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) FROSTBURG			c. LENGTH OF STAY IN 16 HOURS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL			e. STREET ADDRESS ECKHART		
			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRANCES		First	Middle	Last	4. DATE OF DEATH NOVEMBER 19, 1967
S SEX FE MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B DATE OF BIRTH APRIL 22, 1884	9 AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ON HOME		11 BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND	
13. FATHER'S NAME HENRY PAPE			14. MOTHER'S Maiden Name ELIZA COPPAGE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service NO			16. SOCIAL SECURITY NO N.A.		
17. INFORMANT MR. THOMAS WRIGHT, ECKHART			Address MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4201 Acute myocardial infarction					
IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cerebrovascular heart disease. 8 hours					
DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1967 , to Nov. 19, 1967 that (I) (we) last saw the deceased alive on Nov. 18, 1967 , and their death occurred at 3:30 AM , from causes and on the date stated above.					
22a. SIGNATURE G. Paige Strong					
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/22/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ECKHART CEMETERY	
24. FUNERAL DIRECTOR SOYERS, LAFER-SOYERS FUNERAL HOME		ADDRESS 101 N. LAFER, MARYLAND		23d. LOCATION (City or Town) (County) (State) ECKHART, MARYLAND	
VR A15 (4) 20 M 1/64		25a. REC'D BY REGISTRAR NOV 28 1967		25b. REGISTRAR'S SIGNATURE J. James Jagger	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

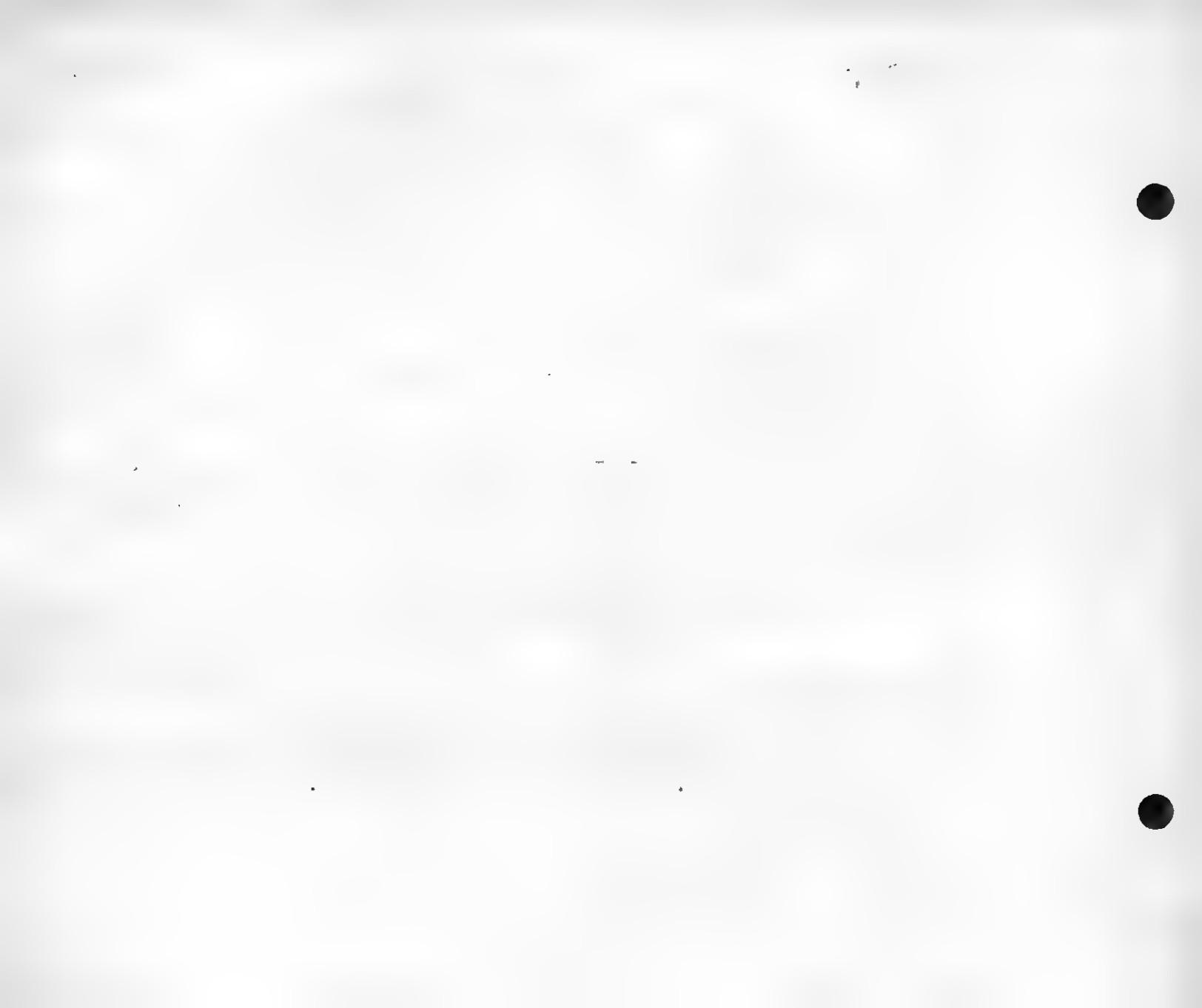
14771

CERTIFICATE OF DEATH

14779

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.
 director, page 3 should be detached for use as the burial/transit permit. When please remove carbon paper. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 12 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street address) SYLVAN RETREAT		e. STREET ADDRESS 921 Silbert Place	
f. NAME OF DECEASED (Type or print) First HELEN Middle WYSNER		g. DATE OF DEATH Month NOV. Doy 5 Year 1967	
h. SEX FEMALE COLOR OR RACE WHITE		i. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
j. DATE OF BIRTH ? 1892		k. AGE (In years last birthday) 75 yrs	
l. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		m. KIND OF BUSINESS OR INDUSTRY none	
n. BIRTHPLACE (County & State, or foreign country) Unknown		o. CITIZEN OF WHAT COUNTRY? USA	
p. FATHER'S NAME JOSEPH WYSNER		q. MOTHER'S MAIDEN NAME MARGARET O'DONNELL	
r. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		s. SOCIAL SECURITY NO 220-52-9778	
t. INFORMANT Address Sylvan Retreat, Cumberland, Md.		u. INTERVAL BETWEEN ONSET AND DEATH approx. 6 days	
v. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lumbaritis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>chr. ASHD</i> DUE TO last (c) <i>Ateriosclerosis</i>		w. DUE TO approx. 6 days several years several years	
x. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Spondylosis</i>		y. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
z. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		aa. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
ab. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		ac. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
ad. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		ae. (City or town) (County) (State)	
af. I certify that (I) (this hospital) attended the deceased from April 15, 1967, to Nov. 5, 1967 that (I) (we) last saw the deceased alive on Nov. 4, 1967, and that death occurred at 8 P.M. from causes and on the date stated above.		ag. DATE SIGNED Nov. 6, 1967	
ah. SIGNATURE <i>John A. Tepper</i>		ai. M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
aj. PHYSICIAN'S NAME (Type) John A. Tepper Esq.		ak. ADDRESS Medical Hospital Cumberland, Md.	
al. BURIAL, CREMATION, REMOVAL (Specify) Burial		am. DATE THEREOF Nov. 9, 1967	
an. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery		ao. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
ap. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ar. ADDRESS NOV 10 1967	
		as. REC'D BY REGISTRAR Charles Judge	
		at. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14780

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14772

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 62 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 448 WILLIAMS STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR		First FREDERICK	Middle ZARGER
4. DATE OF DEATH NOV 30 1967	Month NOV	Doy 30	Year 1967
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST HELPER B&O RAILROAD		9. AGE (In years last birthday) 62 yrs.	
11. BIRTHPLACE (State or foreign country) CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN ZARGER		14. MOTHER'S MAIDEN NAME KATE "CHRISTMAN" ZARGER HOPCRAFT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-05-5257	
17. INFORMANT LILLIAN ZARGER 448 WILLIAMS ST. CUMBERLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4261 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Coronary Occlusion Coronary Sclerosis INTERVAL BETWEEN ONSET AND DEATH Sudden ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3 DEC 67	23c. NAME OF CEMETERY OR CREMATORIAL ST. LUKES CEMETERY
23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.		23e. REC'D BY REGISTRAR DATE DEC 4 1967	
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14773

CERTIFICATE OF DEATH

14781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany County MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland		c. LENGTH OF STAY IN IB 81		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary			d. STREET ADDRESS 619 N. Mechanic Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary		First Mary	Middle E.	Last Zink	4. DATE OF DEATH Month November Day 3 Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1886	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0000
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James McKenzie			14. MOTHER'S MAIDEN NAME Sarah (McKenzie) McKenzie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-8816 D		17. INFORMANT Mrs. Pauline Moyer Address 49 N. Mechanic Street Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart, Heart insufficiency DUE TO Chr. A.S.H.D INTERVAL BETWEEN ONSET AND DEATH approx. 3 days 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis, Generalized many years DUE TO (c) R.V.D with gangrene lower extremities					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) mechanical Hospital	
21. I certify that (I) (this hospital) attended the deceased from Nov 3 , 1967, to Nov 3 , 1967, that (I) (we) last saw the deceased alive on Nov 3 1967, and that death occurred at 6:30 P.M. , from causes and on the date stated above.			22b. DATE SIGNED Nov 4, 1967		
22a. SIGNATURE John A. Tepper		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) John A. Tepper MD		22d. ADDRESS mechanical Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-6-67		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland					
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS 404 Decatur Street, Cumb.		25a. REC'D BY REGISTRAR DATE NOV 7 1967	
			25b. REGISTRAR'S SIGNATURE Charles Judge		

